

MEDICAID REFORM COMMISSION REPORT

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THE MEDICAID REFORM COMMISSION

The Creation

The Medicaid Reform Commission was created under Senate Bill 539, 208.014, RSMo, and Senate Concurrent Resolution 15 (2005). The Commission was charged with writing a report by January 1, 2006, with recommendations for reforming, redesigning and restructuring a new Medicaid system. Members were appointed from their respective houses, with five members from each chamber. The directors from the Department of Health and Senior Services, Department of Mental Health and Department of Social Services served as ex officio members.

Members

Senator Charlie Shields

- Sen. Shields was elected to the House of Representatives in 1990 and was elected to the Senate in 2002.
- He serves as the Majority Floor Leader and serves on the Administration Committee; Education Committee; Joint Committee on Education – Chair; Joint Committee on Governmental Accountability; Joint Committee on Legislative Research; Gubernatorial Appointments Committee; and is Chair of Rules, Joint Rules, Resolutions and Ethics Committee.
- Sen. Shields' experience as the former Chair of Aging, Families, Mental and Public Health Committee combined with his work in the healthcare field provided a wealth of knowledge for reforming the Medicaid system.

Senator Rita Days

- Sen. Days was elected to the House of Representatives in 1993 and served in the House until 2002 when she was elected to the Missouri Senate.
- She serves on the Education Committee; Joint Committee on Education; Governmental Accountability and Fiscal Oversight Committee; Small Business, Insurance and Industrial Relations Committee; Transportation Committee; Joint Committee on Terrorism, Bioterrorism and Homeland Security; and the Joint Committee on Transportation Oversight.
- Sen. Days' experience provided for constructive solutions in reforming Medicaid.

Senator Patrick Dougherty

- Sen. Dougherty has served in the legislature since 1978 when he was elected to the House of Representatives. He was elected to the Senate in 2001.
- He serves on the Administration Committee; Aging, Families, Mental and Public Health Committee; Appropriations Committee; Joint Committee on Leases and Public Oversight; Joint Committee on Legislative Oversight; Joint Committee on Hazardous Waste Generators and Hazardous Waste Facilities; Joint Committee on Solid Waste; Pensions, Veterans' Affairs and

General Laws Committee; and Rules, Joint Rules, Resolutions and Ethics Committee.

- During Sen. Dougherty's tenure in the legislature he has worked on many social issues related to children and families. He also has previously been a caseworker for the Division of Family Services. With his experience, Sen. Dougherty provided great perspective to the Commission.

Senator Michael Gibbons

- Sen. Gibbons has served the state legislature since 1992 when he was elected to the House of Representatives. He was elected to the Missouri Senate in 2000.
- He currently serves as the President Pro Tem and serves on the Administration Committee – Chair; Gubernatorial Appointments Committee – Chair; Pensions, Veterans' Affairs and General Laws Committee; Rules, Joint Rules, Resolutions and Ethics Committee; Joint Committee on Legislative Research; and the Joint Committee on Tax Policy.
- Senator Gibbons has worked hard throughout his career to protect Missouri's children. In 2005, he created the Comprehensive Children's Mental Health System, which protects children with mental disabilities. His work protecting children was essential in creating a new Medicaid program that does the same for all Medicaid participants.

Senator Chuck Purgason

- Sen. Purgason has served the state legislature since 1996 when he was elected to the House of Representatives. He was elected to the Missouri Senate in 2004.
- He currently serves on the Agriculture, Conservation, Parks and Natural Resources Committee; Appropriations Committee; Gubernatorial Appointments Committee; and serves as the Co-Chair of the Pensions, Veterans' Affairs and General Laws Committee.
- As Representative he was the Chairman of the Committee on Appropriations for Health, Mental Health and Social Services. In 2005, he sponsored Senate Bill 539, which created the Medicaid Reform Commission. His experience on budgetary issues was very useful to the Commission.

Representative Margaret Donnelly

- Rep. Donnelly was elected to the House in 2002.
- She serves on Appropriations for Health, Mental Health and Social Services Committee; Budget Committee; Elections Committee; and the Joint Committee on Government Accountability.
- Rep. Donnelly is an attorney with a focus on family and juvenile law and has served her community as a school social worker. Her work as a child advocate brought a wealth of experience to the Commission.

Representative Allen Icet

- Rep. Icet was elected to the House in 2002.
- He currently serves on the Ways and Means Committee; Appropriations – Education; Chairman of the Budget Committee; Joint Committee on Government Accountability; Joint Committee on Legislative Research; Special Committee on Education Funding; Special Committee on General Laws; and is the Chair of the Appropriations – Health, Mental Health and Social Services Committee.
- Rep. Icet’s work on the Appropriations Committee for Health, Mental Health and Social Services provided a great standpoint for the Commission.

Representative Yaphett El-Amin

- Rep. El-Amin was elected to the House in 2002.
- She serves on the Job Creation and Economic Development Committee; Appropriations – Health, Mental Health and Social Services Committee; Fiscal Review Committee; Special Committee on Urban Issues; and Special Committee on Education Funding.
- As an advocate and voice for seniors and children, Rep. El-Amin provided a great perspective for the Commission as it worked toward reform.

Representative David Sater

- Rep. Sater was elected to the House of Representatives in 2004.
- He serves on the Appropriations – Health, Mental Health and Social Services Committee; Health Care Policy Committee; and Elections Committee.
- As a former small business owner and pharmacist, Rep. Sater brought a wealth of experience and knowledge regarding healthcare reform.

Representative Ray Weter

- Rep. Weter was elected to the House in 2004.
- He serves on the Senior Citizen Advocacy Committee; Job Creation and Economic Development Committee; Appropriations – Health, Mental Health and Social Services; Conservation and Natural Resources Committee; and Joint Interim Committee on Missouri Health Care Stabilization Fund.
- Rep. Weter’s experience in the healthcare field provided workable knowledge and vision for the Commission.

Director Julie Eckstein, Department of Health and Senior Services

- Director Eckstein was appointed as the Director of Health and Senior Services in March 2005.
- Prior to her appointment, Director Eckstein was the Executive Director of Health Communities, St. Charles County. She has worked with various community organizations that emphasize healthy lifestyles.
- Her experience in promoting healthy lifestyles was very valuable in creating a Medicaid system that promotes wellness and prevention.

Director Dorn Schuffman, Department of Mental Health

- Director Schuffman was appointed as the Director of Mental Health in December 2001.
- Dir. Schuffman has been working for the Department since 1978. Prior to his appointment as Director he was the Director of the Division of Comprehensive Psychiatric Services.
- His vast experience in the Department of Mental Health has been a great asset to the Commission as it worked toward reform.

Director Gary Sherman, Department of Social Services

- Director Sherman was appointed as Director of the Department of Social Services in March of 2005.
- Prior to his appointment, he has served as the Director of the Division of Youth Services from 1983 until 1985. He then served as the Director of the Division of Aging until 1988.
- His leadership in these roles provided a wealth of experience and knowledge needed in reforming Medicaid.

Hearings

The Commission held 21 meetings since June 28, 2005. Hearings have been held in Jefferson City, St. Joseph, Kansas City and St. Louis. The hearings have been structured with a combination of testimony from experts in the field of healthcare and Medicaid services and from the public. The Commission heard testimony on wide-ranging topics pertaining to Medicaid reform. The following topics have been covered:

- Medicaid Overview and the current program
- Availability and eligibility
- Hospital's perspective
- Technology in healthcare
- Long-Term Care
- Medicaid Reform in other states
- Medicaid and managed care
- Providers' perspective
- Pharmacy
- Mental Health
- Each set of hearings also included public testimony

The Charge

The Commission was charged with recommending a fundamental program concept that achieves the following objectives:

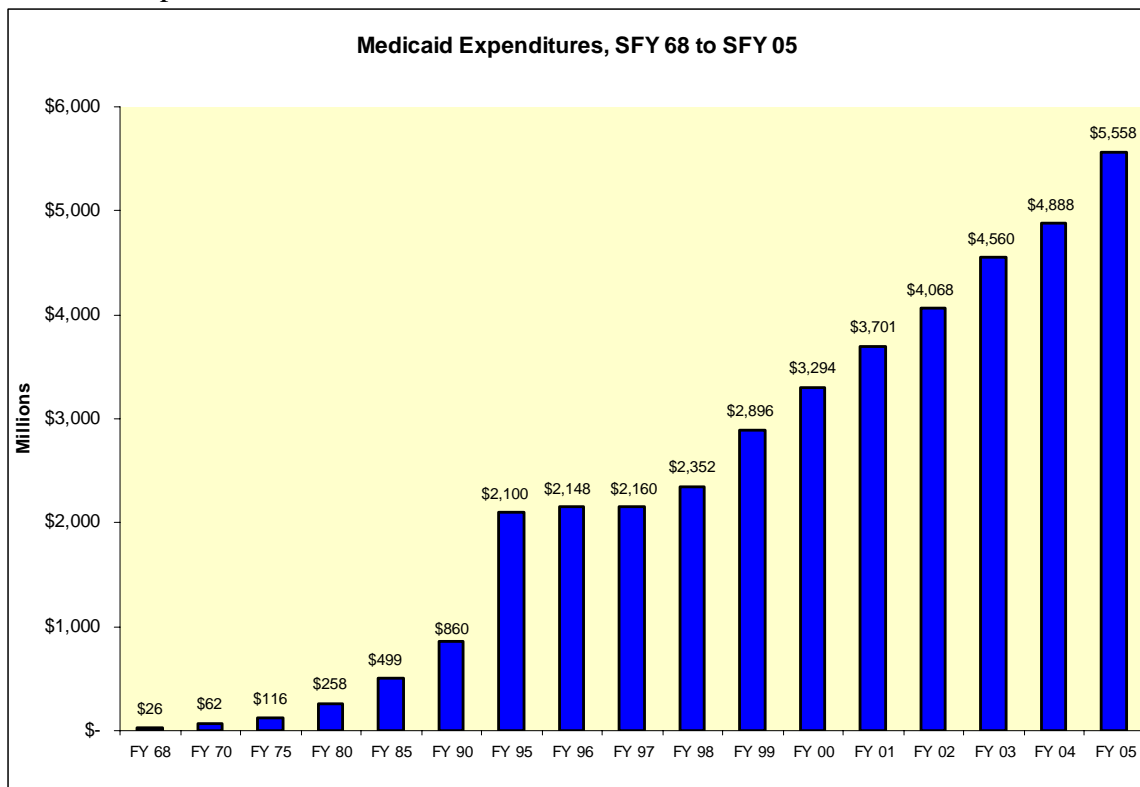
- Improves the health status of Missourians by increasing access to basic healthcare, wellness and prevention.
- Better identifies the needs of participants and develops services that meet those needs and results in the best outcomes at the best cost.

- Ensures appropriate levels of statutory and administrative oversight to improve participation and efficiency by providers while improving access to quality care.
- Provides service options that will encourage the least restrictive setting for the delivery of care, especially as it relates to long-term care.
- Ensures the state budget lives within its means by controlling the financial growth of the public healthcare program and fully utilizing and encouraging the use of private financial resources and private insurance.
- Focuses resources to help those with the greatest need and provides taxpayer resources only to those who cannot afford to provide for themselves.
- Identifies and makes recommendations to eliminate waste, fraud and abuse in Missouri's public healthcare system as it relates to those getting services and those providing services.
- Consolidates as appropriate and administers state medical assistance programs to achieve maximum efficiency and effectiveness.

MEDICAID IN MISSOURI

History of Medicaid

Medicaid was created by Congress, through Title XIX of the Social Security Act in 1965, as a program to provide medical assistance for individuals and families with low incomes and limited resources. Unlike Medicare, the federal and state government jointly funds Medicaid. Missouri began offering health coverage to low-income individuals in 1959 through a limited medical assistance program that covered a portion of inpatient hospital care. This program was expanded in 1963 to include limited coverage for prescription drugs and dental care. Missouri's Medicaid program under Title XIX of the Social Security Act began in 1967, and coverage initially included physician's services, outpatient hospital care, and nursing home care. Eligibility was expanded to include the permanently and totally disabled and blind populations as well as expanding services to families receiving Aid to Families with Dependent Children.¹ In fiscal year 1968, Medicaid expenditures totaled \$26 million dollars.² In contrast, in fiscal year 2005, Medicaid expenditures exceeded \$5.5 billion dollars.³



Although participation is optional, all 50 states take part in the Medicaid program. In exchange for receiving federal matching funds, the federal government requires states to provide certain services to several mandatory groups of recipients. The mandatory eligibility groups include:

- Individuals who meet the requirements of the Aid to Families with Dependent Children (AFDC) group that were in effect in their state as of July 16, 1996;
- Children under the age of six whose family income is at or below 133% of the federal poverty level;
- Pregnant women whose family income is at or below 133% of the federal poverty level. Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and post-partum care;
- All children born after September 30, 1983 who are under age 19 and whose family income is at or below 100% of the federal poverty level;
- Supplemental Security Income (SSI) recipients in most states. Some states use more restrictive Medicaid eligibility requirements that pre-date SSI;
- Recipients of federal foster care and adoption assistance under Title IV-E of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time); and
- Certain low-income Medicare beneficiaries. All Medicare beneficiaries whose incomes are below the federal poverty level receive Medicaid assistance to pay for Medicare premiums, deductibles, and cost sharing. These individuals are known as Qualified Medicare Beneficiaries or QMBs. Medicare beneficiaries whose incomes are slightly above the federal poverty level receive Medicaid assistance for the payment of Medicare premiums and are known as Specified Low-Income Medicare Beneficiaries or SLMBs.⁴

Some services must be provided as part of a state's Medicaid program in order to be eligible for matching federal funds. The following services are considered mandatory:

- Inpatient hospital services;
- Outpatient hospital services;
- Services at rural health clinics and Federally Qualified Health Centers (FQHCs);
- Physician services;
- Laboratory and X-ray services;
- Pediatric and family nurse practitioners' services;
- Nursing facility services and home health services for individuals aged 21 and over;
- Home healthcare for individuals eligible for nursing facility services;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21;
- Family planning services and supplies;
- Medical and surgical services of a dentist; and
- Nurse-Midwife services⁵

In addition to the mandatory eligibility groups and services, Missouri also provides coverage to several optional coverage groups, as well as coverage for several optional services. The optional coverage groups in Missouri include the following:

- ❖ Pregnant women and children up to age 1 from 133 – 185% of the federal poverty level;
- ❖ Children ages 0 – 1 with family incomes above 133% of the federal poverty level; children ages 1-5 with family incomes of 133 – 300 % of the federal poverty level; and children ages 6 through 19 with family incomes of 100% to 300% of the federal poverty level.

Missouri's Medicaid program also provides coverage for several optional services, including the following:

- ❖ Prescription drugs;
- ❖ Nursing facilities for children;
- ❖ In-home services;
- ❖ Home health services for individuals under the age of 21;
- ❖ Mental Health services; and
- ❖ Services in an Intermediate Care Facility for the mentally retarded for individuals over 21 years of age.

Participants and Expenditures

In recent years, Medicaid enrollees and expenditures have increased dramatically. In Missouri, there were 462,090 Medicaid participants in fiscal year 1992 at a total cost of approximately \$1.35 billion, which includes \$403.1 million in state general revenue funds.⁶ By the end of fiscal year 2005 there were 992,622 Medicaid participants and expenditures on behalf of these participants were over \$5 billion, which includes over \$1.3 billion in state general revenue funds.⁷ Rapidly growing Medicaid expenditures have been attributed to factors beyond the control of state governments, such as exploding healthcare costs, federal mandates, and rising levels of poverty due to a declining economy.

Medicaid programs can be broken down into five general categories based on the type of person served: disabled, elderly, adults, pregnant women and children, and eligibility requirements differ for each of these general categories. Each eligibility category consists of two components: an income eligibility guideline and a condition or “categorical” eligibility guideline.

**MEDICAID EXPENDITURES BY LARGE ELIGIBILITY GROUPS
FISCAL YEAR 2004**

Expenditures (in Millions)	*Elderly	**Disabled	Medical Assistance for Families-Adult	Medical Assistance for Families-Child	Foster Care	Medicaid for Children	*** Other Children	****Pregnant Women	MC+ for Kids (State Children's Health Ins Program)	Uninsured Parents	General Relief (Temporarily Disabled)	*****All Other	Total
Federal/State match rate	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 61 / 39	Title XIX 73 / 27	1115 Waiver 61 / 39	Q / 100		
Nursing Facilities	\$571.8	\$133.7	\$0.2	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$705.7
Hospitals	\$51.7	\$422.4	\$89.0	\$91.7	\$7.8	\$58.1	\$18.9	\$33.5	\$16.3	\$0.7	\$3.0	\$2.4	\$795.5
Dental	\$2.7	\$10.3	\$8.8	\$2.9	\$0.2	\$0.9	\$0.3	\$0.9	\$0.3	\$0.0	\$0.0	\$0.0	\$27.3
Pharmacy	\$270.1	\$635.1	\$65.3	\$46.9	\$6.3	\$17.9	\$8.9	\$3.7	\$14.5	\$1.8	\$5.2	\$1.9	\$1,077.6
Physician	\$36.4	\$125.6	\$47.1	\$28.0	\$2.1	\$12.0	\$3.1	\$17.3	\$6.8	\$0.9	\$3.0	\$0.6	\$282.9
In-Home	\$163.7	\$147.9	\$1.3	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.1	\$0.0	\$313.0
Rehab & Spec	\$49.3	\$77.2	\$6.0	\$6.9	\$0.4	\$2.2	\$0.8	\$0.6	\$1.4	\$0.0	\$0.5	\$0.1	\$145.4
Buy-In	\$37.2	\$39.8	\$0.5	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$5.0	\$0.0	\$82.5
Mental Health	\$15.7	\$318.6	\$9.0	\$13.2	\$2.8	\$6.7	\$10.7	\$0.6	\$3.6	\$0.0	\$0.0	\$0.0	\$380.9
State Institutions	\$6.4	\$134.0	\$0.4	\$4.7	\$23.5	\$1.7	\$35.6	\$0.0	\$1.3	\$0.0	\$0.0	\$0.0	\$207.6
EPSDT	\$0.2	\$20.9	\$1.3	\$44.5	\$11.7	\$18.7	\$17.5	\$1.2	\$10.7	\$0.0	\$0.0	\$0.0	\$126.7
Managed Care	\$0.0	\$0.0	\$242.3	\$293.3	\$13.6	\$109.8	\$13.3	\$17.2	\$51.5	\$2.0	\$0.0	\$0.2	\$743.2
Total (in millions)	\$1,205.2	\$2,065.5	\$471.2	\$532.1	\$68.4	\$228.0	\$108.1	\$74.4	\$107.0	\$5.4	\$16.8	\$5.3	\$4,888.4
Number of Enrollees	80,149	143,798	172,649	329,000	12,536	105,641	12,648	15,179	87,280	12,234	3,033	488	974,509
Annual Cost Per Person	\$15,037	\$14,364	\$2,729	\$1,617	\$5,454	\$2,158	\$8,624	\$4,907	\$1,225	\$442	\$5,531	\$10,935	\$5,016
Monthly Cost Per Person	\$1,253	\$1,197	\$227	\$135	\$454	\$180	\$719	\$409	\$102	\$37	\$461	\$911	\$418
Monthly State Cost Per Person	\$484	\$462	\$88	\$52	\$175	\$69	\$277	\$158	\$28	\$14	\$461	##	##

(Source: Table 5 for FY04)

* Elderly includes the following categories: Old Age Assistance (OAA) and Qualified Medicare Beneficiaries (QMB)

** Disabled includes the following categories: Permanently and Totally Disabled (PTD), Aid to the Blind, Blind Pension, Medical Assist. for Working Disabled (MAWD)-Premium and MAWD-NonPremium

*** Other Children includes the following categories: Children in a Vendor Institution, Child Welfare Services (CWS), Div of Youth Services (DYS), Title XIX Homeless, Dependent & Neglected (HDN),

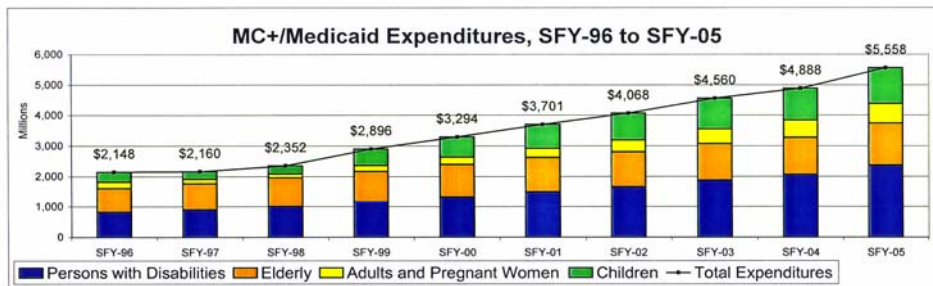
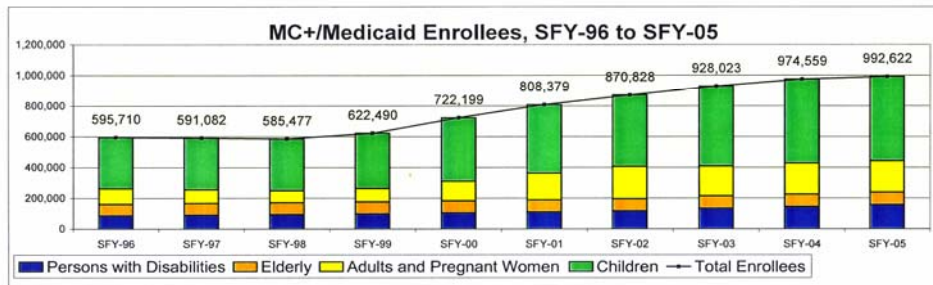
MO Children with Develop Disabilities (MOCDD) and Presumptive Eligibility for Kids.

**** Pregnant Women includes the following categories: Medicaid for Pregnant Women, Presumptive Eligibility and Medicaid for Pregnant Women Poverty

*****All Other includes the following categories: Refugee and Women with Breast or Cervical Cancer (BCGP)

State Monthly Cost per Person and Federal/State match rate vary by category of eligibility.

MC+/Medicaid Enrollees and Expenditures, SFY-96 to SFY-05



Source: Department of Social Services

MC+ for Children

Children receive healthcare coverage through either a state's regular Title XIX Medicaid program, or through the state's Title XXI Children's Health Insurance Program (SCHIP). The Missouri SCHIP is described in the next section.

Federal Title XIX Medicaid coverage requirements for children vary by age. States must cover children up to the age of six who have family incomes below 133% of the federal poverty level. States are also required to cover children from the ages of six through 18 who have family incomes below 100% of the federal poverty level. In Missouri children are eligible for Medicaid coverage under Title XIX using the following guidelines:

- ❖ Newborns up to the age of one with family incomes up to 185% of the federal poverty level;
- ❖ Children ages 1 through 5 with family incomes up to 133% of the federal poverty level;
- ❖ Children ages 6 through 18 with family incomes up to 100% of the federal poverty.

Currently in Missouri, children above these limits with family incomes up to 300% of the federal poverty level may qualify for healthcare coverage through the SCHIP program.

Missouri law does not require a resource test for Medicaid for children, although federal law gives states the option of establishing a resource test. Federal law requires optional resource tests to be no more restricted than the state AFDC level as of July 16, 1996, which was less than or equal to \$1,000 in countable resources per family. Resources that are exempt from "countable assets" include the home and 40 acres surrounding it; \$1,500 equity in one vehicle; one burial plot per family member; property used in the course of business or employment; and household furnishings.

SCHIP – MC+ for Kids

The State Children's Health Insurance Program in Missouri is a subgroup of the MC+ program and is called the MC+ for Kids program or Title XXI. The Balanced Budget Act of 1997 established Title XXI of the Social Security Act creating the State Children's Health Insurance Program (SCHIP). The goal of this program was to help states expand Medicaid coverage to uninsured, low-income children and is a completely optional program.

As an incentive to states to create an SCHIP program, the federal match rate for the program is higher than the match rate for Title XIX Medicaid for children. For state fiscal year 2005, the funding for the MC+ for Kids program was a 72.87% federal and 27.13% state match. This is a significant increase from the standard Medicaid match of 61.5% federal and 38.5% state match. Additionally, federal law requires states that do not spend their annual federal SCHIP allocation to redirect a portion of unspent funds to other states that have spent their SCHIP allocation. Missouri has received significant amounts of these "redirected" funds.

States are required to first determine whether a child qualifies for coverage through the Medicaid for Children program before determining SCHIP eligibility. To enroll in a MC+ for Kids program, children must be under the age of 19, have a family income below 300% of the federal poverty level, and have a family net worth less than \$250,000.

Missouri's SCHIP program has four tiers of eligibility. Children with family incomes up to 150% of the federal poverty level who do not otherwise qualify for Medicaid through a non-SCHIP group are eligible for MC+ for Kids and are not required to pay a monthly premium. Families with children in the SCHIP premium group pay no more than 1%, 3%, or 5% of their income in a year. Children ages 1 through 18 with family incomes between 151% and 185% of the federal poverty level must pay a 1% monthly premium based on family size and monthly income. Children ages 0 through 18 with family incomes between 186% and 225% of the federal poverty level must pay a 3% monthly premium based on family size and monthly income. Children ages 0 through 18 with family incomes between 226% and 300% of the federal poverty level must pay a 5% monthly premium based on family size and monthly income. For example, a family size of four with a yearly income of \$48,000 must pay a monthly premium of \$181 for their children's healthcare coverage. In addition to the participation requirements outlined above for the premium group only, children must also be uninsured for 6 months or have no access to other health insurance coverage for less than \$342 per month.

MC+/Medicaid Adults

Missouri's Medicaid program provides medical assistance for adults who are low-income parents through two programs: Medical Assistance for Families and Transitional Medical Assistance. Federal law requires states to cover Medical Assistance for Families recipients with incomes up to the state's AFDC income level as of July 16, 1996. In Missouri, this is equal to between 18 and 23% of the federal poverty level.

Missouri imposes no asset test on recipients of Medical Assistance for Families.

However, federal law allows states the option of imposing an asset test as long as it is no more restrictive than the state's AFDC level as of July 16, 1996, which was less than or equal to \$1,000 in countable assets. Resources that are exempt from "countable assets" include the home and 40 acres surrounding it; \$1,500 equity in one vehicle; one burial lot per family member; property used in the course of business or employment; and household furnishings.

Low-income parents in welfare-to-work families are also eligible for Medicaid. This group of recipients, known in Missouri as Transitional Medical Assistance, becomes eligible for up to 12 months because they are ineligible for Medical Assistance for Families due to increased earnings. The family must have been eligible for Medical Assistance for Families in three of the six months prior to becoming ineligible due to increased earnings. Income during the second six months of the transitional medical assistance coverage period cannot exceed 185% of the federal poverty level. This is a mandatory coverage group, and federal law prohibits the use of a resource test during the coverage period.

MC+ for Pregnant Women and Newborns

Missouri MC+ for Pregnant Women and Newborns provides Medicaid coverage for pregnant women and their newborn children who have family incomes up to 185% of the federal poverty level. The federal requirement for this eligibility group is up to 133% of the federal poverty level. Missouri Medicaid takes into account the income of the parents of the pregnant minor woman for the purposes of determining financial eligibility for this program. The coverage includes sixty days of postpartum coverage for the mother, and MC+ coverage for one year for the child. A woman's coverage continues throughout her pregnancy and through the postpartum period once she is determined to be eligible, despite any subsequent increases in her income. Even though federal law allows states to implement a resource test for pregnant women, Missouri law does not require a resource test for this category of Medicaid eligibility. Federal law states a resource test can be no more restrictive than the July 16, 1996 limit for AFDC of \$1,000.

Elderly, Blind and Disabled Individuals

Medicaid is the general term for medical assistance provided to elderly, blind, and disabled individuals. Individuals who receive Medical Assistance, Nursing Care, Home and Community Based Services, General Relief, Supplemental Aid to the Blind, Blind Pension, and Adult Supplemental payments receive Medicaid services on a fee-for-service basis.

The elderly represent 8.2% of the state's Medicaid participants, and expenditures of the elderly equal \$1.2 billion or 24.6% of total expenditures. Dual eligibles are a significant sub-group of the aged and disabled Medicaid recipient population. Dual eligibles are individuals who qualify both for Medicaid and for Medicare. If Medicare recipients who qualify as QMBs or SLMBs also meet the Medicaid income and resource guidelines, they can receive Medicaid. The state Medicaid program is required by federal law to pay Medicare premiums and co-insurance, as well as Medicare deductibles for individuals who meet income guidelines.

In Missouri, there were 161,000 dual eligibles in 2003, which represents 17.3% of the total Medicaid population, but 75.4% of the aged and disabled enrollees. Nationally, there were 7,468,000 dual eligibles in 2003, which was 14% of all enrollees and 58% of aged and disabled enrollees. Missouri spent \$1.9 billion on dual eligibles in 2002.

The aged population is considered to be those age 65 and older. The income threshold for the elderly or aged population who are living in their homes is currently 85% of the federal poverty level or \$678 per month for one person, and \$909 per month for a couple. The asset limit is \$1,000 for an individual and \$2,000 for a couple. Individuals who have incomes that exceed these limits can spend down to the eligibility limit. The spenddown amount can be met by either providing receipts for medical expenses and bills that the individual has paid, or by paying the spenddown amount by check or direct deduction from the individual's account.

Individuals who are receiving Medicaid in nursing facilities are subject to an income limit eligibility requirement with their excess resources going first to pay for the cost of

care, and then Medicaid pays the balance. The asset limits for nursing home residents are also \$1,000 for a single person and \$2,000 for a couple.

Individuals who are receiving home and community-based services paid for by Medicaid have a monthly income limit of \$678 for one person. This income limit is only applicable to the individual needing the services. Home and community based service recipients also go through the division of assets described above, and then the asset limit is \$1,000 for the person needing services.

Individuals with disabilities represent 14.7% of Missouri's Medicaid population, or 143,797 individuals as of May 2005. Individuals with disabilities represented 42.2% of Medicaid expenditures, which represents the largest proportion of Medicaid expenditures.⁸

There are two primary pathways for individuals with a disability to become qualified for Medicaid. The first pathway applies to individuals who are receiving SSI or Social Security Disability (SSD) payments. The Social Security Administration determines disability for purposes of these programs, and Missouri's Medicaid program accepts the disability determination for purposes of Medicaid eligibility.

The second pathway for an individual with a disability to qualify for Medicaid is to be determined disabled by the State of Missouri. Eleven percent of individuals receiving Medicaid because of a disability became eligible through this pathway. Physicians who contract with the Department of Social Services, using the Social Security Administration's listings, make disability determinations.

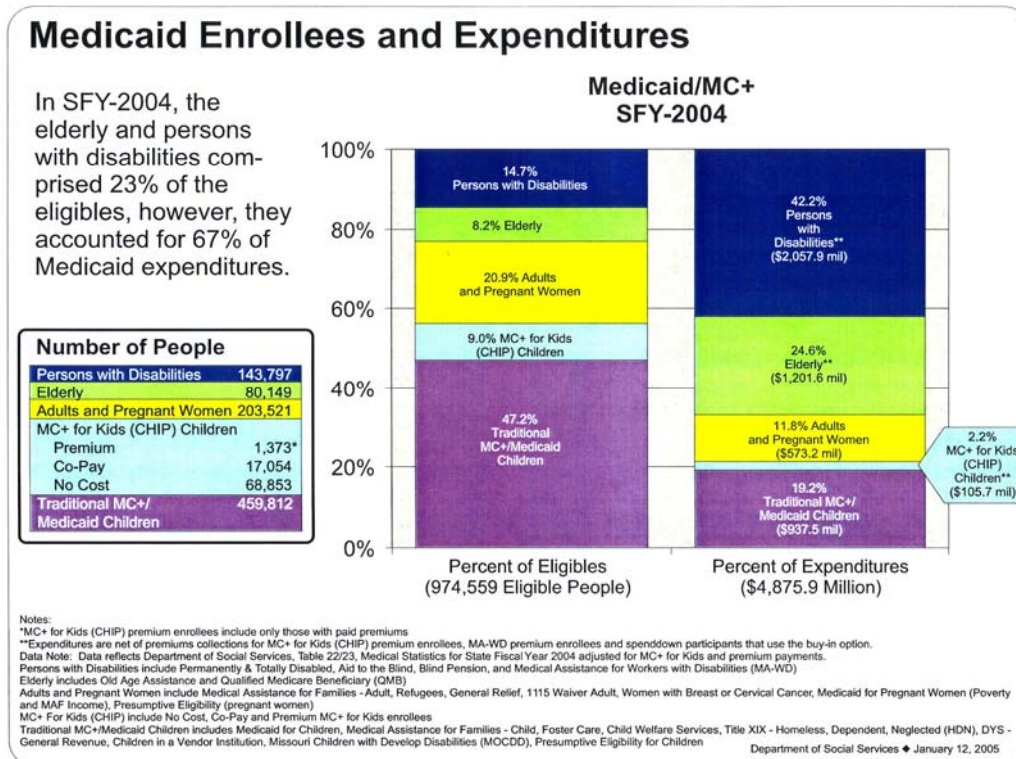
Medicaid expenditures generally follow what is known as the "80/20 Rule;" that is, eighty percent of the participants account for twenty percent of the costs and twenty percent of the participants account for eighty percent of the costs. Children are by far the largest group of eligible individuals, comprising 56.2% of the Medicaid participants in Missouri in fiscal year 2004.⁹ However children represented just 21.4% of the Medicaid expenditures in fiscal year 2004.¹⁰ In contrast, disabled and elderly individuals represented 22.9% of Medicaid participants, but accounted for 66.8% of Medicaid expenditures in fiscal year 2004.¹¹ In other words, two out of every three dollars are spent on elderly or disabled individuals in the Medicaid program.

Participant Satisfaction

Missouri law requires all managed care organizations operating in the state to provide information regarding quality of care, availability of care, member satisfaction, and member health status annually to the Department of Health and Senior Services.¹² Each health maintenance organization (HMO) is evaluated on its Medicare, Medicaid, and commercial product lines and the evaluations are summarized in publications prepared each year by the department.¹³ Currently, children and adults in 37 Missouri counties on the I-70 corridor receive Medicaid covered services through the MC+ managed care program.¹⁴ These individuals are included in the managed care plan performance study group. In the 2005 Consumer Guide to MC+ Managed Care in Missouri, 78% of all

Medicaid managed care recipients rated their managed care plan highly, and 80% indicated that they did not have problems getting necessary care in a reasonable time.¹⁵

Missouri does not conduct surveys of the fee-for-service Medicaid population to gauge participant satisfaction.



Provider Satisfaction

While the Medicaid program in Missouri has grown in recent years in terms of cost and coverage, provider satisfaction and participation with the program is low. Countless comments from providers and surveys reveal certain recurring themes and complaints with the current Medicaid system.

The recurring issues that emerged as feedback from a recent Missouri Academy of Family Physicians (MAFP) survey include: administrative obstacles, poor reimbursement, low specialty participation, lack of a formulary for covered medications, incorrect or ineffective patient eligibility determinations, and non-compliance of Medicaid patients.¹⁶

Though a more in-depth discussion on provider satisfaction and participation will follow later in the report, of note at this point is that of the physicians responding to the survey, 70% indicated that there are not an adequate number of participating physicians in their

respective counties delivering care to Medicaid patients.¹⁷ Furthermore, when asked what factor or factors contribute to the low participation, 48% of the respondents indicated that it is low payment, while 18% indicated that it is low payment *and* administrative burdens.¹⁸ Testimony from a presentation by the Missouri State Medical Association (MSMA) to the Medicaid Reform Commission echoed the same themes regarding physician concerns with the lack of access to care for Medicaid and other low-income patients due to the extremely poor reimbursement rate in Missouri.¹⁹

MEDICAID FOR THE 21ST CENTURY

Basic Principles

The Commission believes that it is in the best interest of the state that all Missourians have affordable healthcare available to them. Therefore, substantial Medicaid and healthcare reform must take place in order for all Missourians to have the availability of quality healthcare. To ensure that the state can continue to provide Medicaid services, the legislature must move toward a reformed, effective Medicaid program. In its current form, the Medicaid program struggles to adequately provide quality care to participants, while failing healthcare providers and Missouri's taxpayers. The cost of the program is growing so rapidly that the state can no longer afford it and furthermore, the program does not adequately meet the needs of vulnerable Missourians. The newly reformed program will address the needs of Missourians, while spending the taxpayers' money wisely. This transformation will focus on the Medicaid system but will also be a model for the private healthcare system as well.

As with any reform measure, the manner in which it is communicated can determine the outcome and success. Like the Three R's of education (Reading, Writing, and Arithmetic), healthcare boils down to the Three R's: Risk, Responsibility, and Reward. Each Medicaid reform proposal should be put through the basic test of the Three R's. Does the reform proposal reduce risk to the state and/or individuals? Does the reform proposal encourage the state, employees, and/or individuals to take responsibility? Does the reform proposal result in tangible rewards?

Risk

Risk involves actions taken by both individuals and the state as purchasers, and the state as the regulator of healthcare. As individuals, our behaviors and lifestyles may put us at higher risk for more significant health problems down the road. These may include a lower quality of life, less productivity in work or school, and more costly healthcare to the state, employers, and to ourselves. From the state's perspective, risk has financial, disease management and administrative components. Financially, the state continues to risk pouring a higher percentage of budget dollars into the Medicaid program. The risk of crippling or totally eliminating other programs increases as Medicaid consumes more resources.

Risk is also increased by unnecessary and outdated state and federal regulations and policies currently applied to the Medicaid program. Cumbersome regulations increase cost, decrease competition and may make accessing care more difficult. Federally initiated obstacles include prohibitions on direct consumer marketing, non-mandatory co-pays, and failure to "lock" a recipient into a medical home. These types of regulations and policies impede a fair and competitive market for the state's business.

Responsibility

Like risk, responsibility is two-fold. The state is responsible for administering the Medicaid program; paying for it and determining how much of Missouri's limited budget

dollars are allocated for Medicaid healthcare costs. Individuals are responsible for managing their own health status, including seeking healthcare at the right time, in the right place and with the right provider; in addition to adopting lifestyle habits which promote good health.

Within its administrative oversight role, the state must take the responsibility to promote good health outcomes through its procurement process and promotion of good health to individuals.

The trend of shifting healthcare costs in commercial population from employers to employees is also being adopted in states for their Medicaid population. These programs shift responsibility to individuals anticipating they will make healthy lifestyle and healthcare buying decisions.

Reward

The current Missouri Medicaid program limits the rewards that may be utilized to change participants' behavior. It is common in commercial insurance to utilize either a stick or carrot approach (or both) to prompt behavior changes. These are tiered co-pays, coinsurances and deductibles. For a number of reasons, these have not been widely used in the Medicaid population. The addition of reward systems may help change patterns and behaviors through preventive health programs.

In summary, by bringing healthcare back to the basics and promoting the three R's, Missouri could successfully gain a healthier population and a healthcare budget that is more manageable than today's out-of-control healthcare system. Promoting the three R's of healthcare is a simple, easily comprehended way of engaging all Missourians in the effort to make Missouri's healthcare program more efficient and affordable.

Transparency

Additionally, to ensure a truly transformed program, there must be increased transparency, increased availability of quality care and an emphasis in technology.

The Commission's vision of an effective Medicaid program is a transparent healthcare system without fraud or abuse. There must be more quality and cost transparency in the Medicaid program and in healthcare as a whole. Most people, either with private or public insurance, do not know the cost of healthcare. By creating a transparent program, participants will be more aware of the real cost to fill a prescription or the cost difference between an emergency room visit and an office visit. When making a major purchase, such as a car, American consumers search for the best product for the best price. There must be more information available to patients so they can make the same educated decision about their healthcare. As consumers of healthcare, all of us must be more aware of the costs. The state should be on the front lines of transparency and should encourage the private sector to follow.

The quality of care must also be more transparent for participants. Participants must be provided with quality information on facilities and providers that deliver care. This

transparency will allow participants to choose the best care for their needs and give an incentive for providers to deliver quality care to all their patients. When individuals are empowered with knowledge, they will make better, more prudent choices about their health. There is nothing more valuable than life and individuals should be given more information to make the best decisions to improve the quality of their lives.

Availability

This redesigned system would also include an emphasis on increased availability and increased provider and participant satisfaction. By doing so, providers will be encouraged to provide services, thereby increasing availability to participants. While Medicaid participants will have better availability of care, they will also be encouraged to take more personal responsibility in their own healthcare decisions. Empowering individuals to take part in their own healthcare decisions is necessary in developing a reformed Medicaid system. Medicaid participants who have a personal investment in their healthcare decisions will be more likely to make prudent decisions regarding their health and the health of their family members. By encouraging better utilization of services and preventive healthcare, Missourians will be healthier and the state will save money.

Technology

Technology will be emphasized in the new Medicaid program. Healthcare is on the cutting edge with new drug research, advancement in technology and overall improved care. Although technology is prevalent in patient care, there is much more that can be done to improve services to patients and reduce administrative burdens. Technology in the healthcare industry is limitless and the state recognizes a great opportunity to be a part of this technology revolution. The Commission recommends supporting measures for the use of electronic medical records, community health records, personal health records and e-prescribing. If used properly, this technology can boost provider and participant satisfaction, improve patient care, reduce administrative burdens and save the state money.

Technological advancements can save lives, money and time. The state should support the use of technology and ensure that the confidential information provided is protected. Providers and participants should be protected from individuals who may try to obtain private information from the technology used to improve care. Therefore, individuals violating privacy laws shall be vigorously prosecuted and the penalties shall be harsh.

Transformation

The new Medicaid program will continue to provide needed assistance to those with low incomes, the disabled, elderly, pregnant women and children. The reformed system, however, will provide this assistance in a more efficient, cost-effective manner. The recommendations in this report will address the three major components of reform: eligibility, availability and delivery of care. The state must determine who is eligible for assistance, where participants can access that assistance and how it will be delivered. In the context of these three components, the report will address the following issues:

- Wellness, prevention and responsibility
- Provider participation and satisfaction
- Managed care
- Technology
- Mental health
- Long-term care
- Pharmacy
- Availability of quality care
- Eligibility

Each of these issues will have specific recommendations for reform and a timeframe for implementation. By addressing these components, Missouri's Medicaid program will be a model for other states as they look toward reform. Above all, Missouri will have a 21st Century Medicaid program that will protect the most vulnerable in a careful and cost-effective manner.

WELLNESS, PREVENTION, AND RESPONSIBILITY

The Commission recognizes that each year the government and society in general spends a large amount of money nationally on healthcare. The majority of these expenditures are for treatment of diseases and injuries, while only a very small amount is spent on prevention. An individual's health status is determined in large part by lifestyle and behavior, and to a lesser extent by genetics, the environment, public policy, and the healthcare system. With this in mind, the Commission will make recommendations on the following:

- The impact of lifestyle and environmental issues on health status and as a driver of cost
- Health promotion and education
- Screening and early diagnosis
- Worksite and community wellness programs
- Chronic disease management
- Public policy that impacts health
- Creation of a culture of health
- Long-term care planning

The “Cost” of Healthcare

Each year a tremendous amount of resources are spent on healthcare. In 1998, the United States spent \$1.15 trillion dollars on healthcare and it is projected that in 2007, the cost will rise to \$2.13 trillion.²⁰ The current amount is 50% higher than the next highest country on a per capita basis. Health outcomes in the United States do not rank high compared to other industrialized countries. The American rates of overweight, obese and chronic conditions top those of other countries. People live longer but not healthier lives. While this country's medical advances might be the best in the world, many go without access to basic healthcare. Findings from the 2004 Missouri Health Insurance Coverage and Access Survey, conducted between March 2004 and July 2004, show that the overall level of chronically uninsured in Missouri, across all age groups, was 8.4 percent or approximately 463,000 individuals.²¹ However, there is a significant number of Missourians that may be temporarily uninsured due to temporary unemployment or seasonal employment. They are either unable to afford healthcare coverage or simply go without because they believe coverage is not worth the expense.

After a cursory comparison of the above cited health expenditures against what is spent on investing in prevention, it is easy to conclude that not enough is invested on the factors that are widely known to have an impact on an individual's health status. Lifestyle choices, environment, human biology, and medical care all factor into a person's health and well-being.

Lifestyle Choices

Fifty percent of factors that impact health status are lifestyle and the choices individual's make each and every day about what to eat, whether to exercise, whether to wear a seat belt in the car or a helmet while biking, etc. It is known for example that each year in Missouri smoking causes more than 9,700 deaths.²² Healthcare costs from tobacco use in Missouri account for over \$1.96 billion annually.²³ Approximately \$490 million of this amount is in Medicaid costs.²⁴ Obesity is second only to tobacco as the leading cause of preventable death in the United States resulting in more than 300,000 premature deaths nationwide each year. National expenditures for overweight and obesity-related conditions have surpassed 78.5 billion and in Missouri, obesity-attributable medical expenditures in 2000 were \$1.6 billion.²⁵

Environment

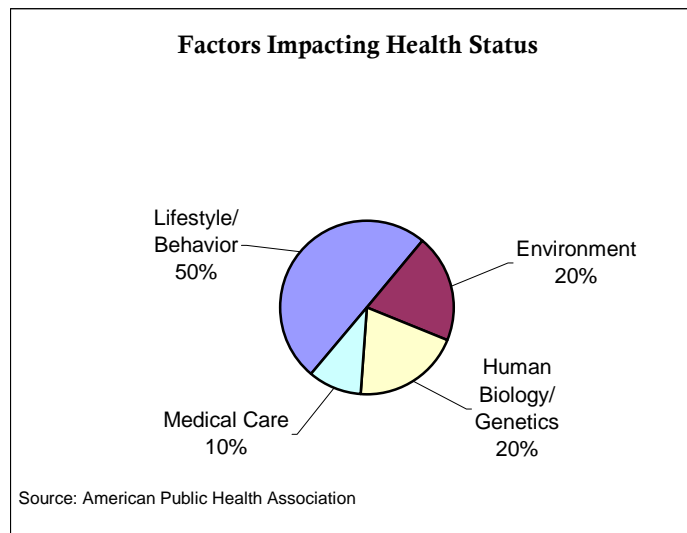
Twenty percent of the factors can be attributed to the environment. Environmental factors include infrastructure issues such as the availability of sidewalks, walking trails etc. The factors also include safety issues and toxins around us, such as environmental smoke from tobacco products. The environmental component to health status, as well as other areas of health impact, is greatly impacted by public policy.

Human biology

Twenty percent of the factors result from human biology and genetics. The Commission could have an impact on these factors. For example, an impact could be made with early identification of genetic problems through newborn screening, etc.

Medical Care

Only ten percent of the factors impacting an individual's health status are derived from medical care or the medical system and yet this is where the state's healthcare resources are primarily directed.



The three items that together account for 80% of those factors; lifestyle, environment and a portion of the medical care system (insurance plan design and technology) provide the

greatest opportunity for better health. Investment in greater resources for education, prevention and wellness are the best strategy for improving health and reducing the cost of healthcare.

Healthy Missourians

Public policy makers should consider the importance and scope of health in other seemingly unrelated issues. From an economic perspective Missourians are suppliers or an input for economic development and education. By improving the health status of Missourians, a healthier workforce is created. A healthier workforce should lead to greater productivity, less absenteeism and lower healthcare costs for the employer. Workforce and healthcare costs are key issues in business recruitment and retention. Creation of a healthier workforce can be used, as an additional economic development tool in the work of creating a business climate that will attract businesses and jobs to Missouri.

Furthermore, Missouri's educational system is a supplier or input to a well-trained workforce. Studies show that healthier kids perform better in school. A conscious effort to improve children's health can be a component of the solution to improve test scores, academic performance, ACT testing rates, scores and the number of students that pursue advanced education and training. Missouri and its education system should adopt an evidence-based approach to address health factors that impact performance such as physical activity and nutrition. These school-based opportunities are not meant to supplant or substitute from the important work and responsibility of parents but rather to support and reinforce what should be taught at home.

Recommendations

Missouri will have an infrastructure including a safety net that will support efforts to be the healthiest state (population) possible. Part of the vision must incorporate the creation of a culture of health. Missouri will become known for its dedication and passion for health with intended outcomes to include better health for each citizen, greater economic success for its businesses, more successful outcomes in education due to healthier children, creation of a "place" where people will want to live, work, play, learn and celebrate life. Therefore, the Commission recommends that the state do the following:

1. Implement a Medicaid program that emphasizes personal responsibility for individual behaviors and health status as identified by health risk appraisal or other instrument.
2. Create a healthcare environment that provides basic level of services for each individual, including annual physical and preventive screenings (those identified as evidence based, cost-effective by age, etc.).
3. Develop mechanisms that increase understanding of our own health through improved health literacy.

4. Create structures to guide participants to become better consumers of healthcare. This new structure should include more transparency on the true costs of care and encourage participants to take responsibility for their own personal health.
5. Create self-guide charts for participants to use to better understand their personal health.
6. Develop and create nurse information and triage lines.
7. Provide health coaches to guide participants in their health maintenance and improvement process.
8. Create evidence based health promotion and education programs.
9. Include interventions that are consistent with our knowledge of the importance of maternal/child health.
10. Create policies and interventions that demonstrate population health as a priority for the greatest good of Missouri citizens.
11. Encourage participation in education programs and behavior modification prior to the authorization of services and pharmaceuticals for each illness and/or disease. This would exclude emergency treatment. For example, chronic disease prevention/management/education program prior to treatment.
12. Encourage a balanced allocation of resources between prevention and the treatment of disease and illness. The state should invest in preventive service including evidence based “complimentary medicine.”
13. Establish and expand use of preventive services and evidence-based practice with chronically ill participants. This would include use of tools such as chronic care management, paying for care according to established standards of care and paying for tobacco cessation counseling.
14. Create data and automation systems that provide critical information about the population served, financial issues, critical management information and health outcomes to support decision making by factual information.
15. Implement technology that provides central point of entry for all state services. This technology should be a central database, single plan of care for each client that ensures that the preventive interventions are part of the coordinated care plan of each consumer.
16. Integrate prevention into the use of technology through electronic medical records to empower individual and community level health decisions and integration/coordination of care by providers.
17. Identify all state and federal health related expenditures in Missouri to ensure consistency with health goals of Missouri’s safety net plans. This identification should include food stamps, housing development, economic development, and public safety.
18. Encourage schools to promote healthier lifestyle choices for students in the areas of nutrition and physical activities.

PROVIDER PARTICIPATION AND SATISFACTION

As stated earlier, provider satisfaction and participation with the program is low. Countless comments from providers and surveys reveal certain recurring themes and complaints with the current Medicaid system.

Better Availability of Physicians

The state should improve availability of quality care by increasing Medicaid physician fees. According to the Missouri Medical Association, Missouri is among one of the lowest payers in the nation, far worse (usually less than half) than what neighboring states pay, and only about 55% of what Medicare pays.²⁶ These rates do not begin to cover the cost of providing the service, which is only about 35 cents on the dollar. Many physicians have no choice but to limit their participation in Medicaid. Consequently, patients often do not have access to appropriate care. Long waits, especially for specialty care, result in complications, expensive and unnecessary emergency room visits, hospitalization, and higher costs.

The Commission also recommends establishing a review board comprised of physicians, a physical therapist, a social worker, a financial consultant and a pharmacist to review cases, which, because of circumstances may need to be evaluated for special needs for benefits through the Medicaid program. Such a review board is necessary because even though on the surface a recipient may not meet the eligibility criteria, the patient's functionality may need to be considered.

Reduce Administrative Burdens

Low pay is not the only factor driving physicians out of the Medicaid program. The administrative burdens are numerous. Through the use of technology the state could improve the prior authorization and claims payment process to ease the burden. Additionally, physicians need an easier eligibility determination process and better access to formulary restriction rules. Further, the Medicaid system needs to implement electronic medical records.

Patient Compliance

Although some of the following issues are discussed elsewhere in the report, the Commission recognizes that in order to improve provider participation there needs to be better coordination and continuity of care through the concept of a medical home. Medicaid participants need to practice personal responsibility and maintain healthy lifestyles. As a result, patient education and awareness programs should be established for recipients to reduce the abuse of the healthcare system.

Along with patient awareness and education, the Commission recognizes that the implementation of co-pays would also serve to promote personal responsibility and healthy lifestyles. If the participant has a financial as well as personal stake in his or her healthcare process, no matter how big or small, it would ensure patient compliance, lower unnecessary utilization of services, and empower the participant.

Another recommendation would include exploring a system whereby emergency room physicians are allowed to screen patients and refer them to a more appropriate level of care. If a patient repeatedly visits an emergency room for non-emergencies, the patient should be held accountable in some manner.

Performance Incentives

The Commission recognizes that providers should provide quality healthcare for participants. Recent studies have shown that the “Pay-for-Performance” programs can improve both medical care and the quality of life by giving healthcare providers a financial incentive to seek measurable improvements in the health of their patients.²⁷ Therefore, the Commission recommends exploring a pilot program whereby providers are rewarded for providing quality and efficient care through financial or non-financial incentives, such as providing support for updating infrastructure and technology.

Provider Fraud

The Commission recommends exploring mechanisms to prevent fraudulent providers from doing business in Missouri. Further, the state needs to centralize and integrate claims systems as to prevent provider fraud.

Utilization of a higher level of technology would also assist the state and the provider in keeping up with any changes in the program and help prevent provider fraud.

Recommendations

As noted above, provider satisfaction and participation with the Medicaid program is low. Countless comments from providers and surveys reveal certain recurring themes and complaints with the current Medicaid system. Therefore, the Commission recommends that the state do the following:

1. Increase provider reimbursement rates.
2. Establish a review board to evaluate special needs cases.
3. Through the use of technology, improve the prior authorization and claims payment process.
4. Explore a tiered level of co-pays to assist with patient compliance and empowerment.
5. Explore a system whereby emergency room physicians are allowed to screen patients and refer them to the appropriate level of care. If a patient repeatedly

visits an emergency room for non-emergencies, the patient should be held accountable in some manner.

6. Explore mechanisms to prevent fraudulent providers from doing business in Missouri. Further, the state needs to centralize and integrate claims systems as to prevent provider fraud.

COORDINATED CARE

The Medicaid managed care program in Missouri is referred to as the MC+ Managed Care program. It is a medical assistance program for low-income families, pregnant women, children, and uninsured parents, who are required to enroll in their choice of seven managed care plans. MC+ Managed Care started in Missouri in 1995. Missouri is one of 48 states that currently have a Medicaid managed care program. Currently only 37 counties, all of which fall along the I-70 corridor, are participating in the MC+ Managed Care program.

With the reform of Medicaid, the state is moving to a system of care with more personal responsibility, which will allow the participant to make better decisions about their own care. Therefore, the Managed Care program will be changed to the “Coordinated Care” program to signify that the new healthcare system adopted by the state is a coordinated effort between the participant, the state, and Coordinated Care Organizations.

One proposal to reduce the state’s current financial risk is to expand MC+ Coordinated Care to other regions and populations within Missouri. By transferring recipients from fee-for-service programs into coordinated care, the financial risk for their healthcare costs is shared between the state and coordinated care organizations (CCO). It also allows the state to provide more scrutiny of waste, fraud, and abuse.

The movement of more citizens into coordinated care could be phased in through expansions into the following areas:

- Children and families in the St. Joseph area
- Children and families in the Springfield area
- Children and families in the counties contiguous to the current I-70 corridor, particularly in suburban rings around the St. Louis and Kansas City area
- Aged, blind and disabled (ABD) in existing coordinated care areas through a pilot program

The ABD population is much more difficult to address than the healthy adults and children population. This is witnessed by the nearly 10 years that managed care has existed in Missouri without expansion to this population, even though they are by far the most expensive population. The fear amongst the advocates for the disabled and mentally ill is that care will be rationed, not managed. There is some basis for that fear.

If an expansion of coordinated care for the ABD population were to occur, it would make sense to pursue an expansion first in the existing coordinated care areas through a pilot program, which would require a waiver to begin such expansion; an immediate expansion into all areas of the state would be ill advised. Since Medicare Part D is covering the prescription drug costs for dual eligibles, the population that could be covered by a purely capitated coordinated care system (that covers all services) is significantly smaller than the universe of ABD Medicaid eligibles. It is possible to do coordinated care for dual

eligibles, but arguably, if the state went this route, they would be the last group to be taken in.

With a smaller ABD population to be served by coordinated care, the importance of correct actuarial rate setting is even more important, in which no actuarial data currently exists for rate-setting for this population in Missouri. However, there are more than 20 states that have their ABD populations in full-risk managed care, so there is some experience base that can be drawn upon.

Also, the potential for pushback by the ABD population to be serviced is significant. The state would require the CCO to maintain a high level of customer satisfaction and protections for the ABD population while maintaining guaranteed savings. This would require a strong contractual arrangement between the state and the selected coordinated care entity that demands the highest level of service and patient care, and establishes financial penalties for failure to perform.

One option would be to put a medical loss ratio maximum in any new contract. For instance, require the CCO bidding on coordinated care for the ABD population to operate at a minimum direct care expense (or looked at the other way, no more than a certain percentage of the contract can be for administration, overhead, and profit). If the direct care percentage were not reached, the difference between expenditures on direct care and the minimum rate established for direct care would have to be rebated to the state, not retained by the CCO.

This agreement would require a proactive, rather than reactive, approach to care coordination. All consumers would receive a health risk assessment that goes far beyond a clinical paradigm to include functional status and barriers, social supports, and unmet behavioral and mental health needs. Independent satisfaction studies and monthly reporting of key indicators such as complaints, prompt payment of providers, call center statistics and denials of care would create an early warning system.

Consumer protections included in the coordinated care contractual arrangements would include a continuity of care requirement that stipulates maintaining a consumer's existing plan of care and penalty provisions that would ensure that the coordinated care entity is held accountable for the preventable nursing home admissions for its members.

A different approach to coordinated care is the establishment of an administrative services organization (ASO) to run coordinated care for the ABD population through a pilot program. An ASO would be contracted by the state to manage this ABD population, but would not take financial risk on a capitated basis. The state would still be at financial risk for their care, although the ASO would have to meet certain performance standards (such as reduced inpatient and outpatient utilization, increased primary care visits, etc.) in order to properly provide incentives for the ASO to manage care and costs. Typically, if these performance standards were met, the ASO would receive an incentive payment. Also, the ASO would not be processing claims, thereby ensuring the economies of scale through the current fiscal agent contract are retained.

More importantly, with an ASO, since the ASO is not at financial risk, advocacy groups would arguably be less concerned about the rationing of care, since the ASO arguably would not directly benefit financially from any necessary care that was not delivered. An ASO would have some of the same problems with CMS, in that a waiver will be necessary, but also it would allow the state to move faster in implementation, since the actuarial study and rate negotiation process could be bypassed.

Recommendations

The Medicaid Reform Commission acknowledges that the Coordinated Care model can be expanded to other areas and Medicaid population groups throughout the state but understands that some of these populations require a high level of specialized care. Therefore, the Commission recommends that the state do the following:

1. Expand coordinated care to children and families in the St. Joseph area.
2. Expand coordinated care to children and families in the Springfield area.
3. Expand coordinated care to children and families in the counties contiguous to the current I-70 corridor, particularly in suburban rings around the St. Louis and Kansas City area.
4. Expand coordinated care to the Aged, Blind, and Disabled in existing managed care areas through a pilot program.
5. Put a medical loss ratio in any new contract, which would require the MCO to operate at a predetermined percentage of funding for direct patient care (or looked at the other way, no more than a certain percentage of the contract can be used for administration, overhead, and profit).
6. Establish an administrative services organization (ASO) to run the coordinated care for the ABD population through a pilot program in existing coordinated care areas.
7. Require the CCO to maintain a high level of customer satisfaction and protections for the ABD population within the pilot program.

TECHNOLOGY

Innovation

The Commission met on July 27, 2005 to hear testimony regarding healthcare technology. The Commission heard testimony regarding new and innovative ideas on ways that technology can improve the delivery of care, reduce administrative burdens and reduce waste, fraud and abuse. Missouri's outdated and antiquated Medicaid program needs to be updated with innovative healthcare technology. By reforming Medicaid, Missouri has a unique opportunity to be on the forefront of technological healthcare endeavors. For the Medicaid program to be successful, it must encourage provider participation and satisfaction, while keeping its participants healthy and safe. If the program remains in the 20th Century, the state will continue to stifle its participants, providers and taxpayers. A program for the 21st Century should use and promote more innovative technological advances that can save lives and money for the state. The Commission recommends more extensive use of the following:

- Electronic medical records
- Community health records
- Personal health records
- E-Prescribing
- Telemedicine
- Telemonitoring

By implementing these programs, the state will be providing healthcare to the most vulnerable in a safe and efficient manner. The state will also ensure providers and participants that the information provided through technology will be protected. Individuals that violate privacy laws by obtaining confidential information will be prosecuted vigorously and punished harshly for their offense.

Electronic Medical Records

The Commission recommends a wide-based use of electronic medical records (EMRs) in Medicaid providers' offices. EMRs are an important tool in healthcare that assists in providing safe, effective healthcare to patients. EMRs reduce administrative burdens, a cause of low provider participation. They also decrease medical mistakes by reducing duplication and delays in the delivery of care. According to a recent survey by the American Academy of Family Physicians, 78% of physicians believed EMRs improved care. The same percentage would also recommend EMRs to a colleague.²⁸ EMRs provide real-time information about a patient that is essential in delivering the best care.

Additionally, by linking through electronic medical records, the state can better evaluate abuses by providers and participants. EMRs provide the up-to-date information needed to ensure that taxpayers' money is being spent wisely.

Cost and implementation are major barriers that providers encounter when deciding to use EMRs. The American Academy of Family Physicians' survey also reported the major barrier preventing physicians from implementing EMRs was the cost.²⁹ The Commission recommends providing incentives to providers who implement and use electronic medical records. The state should increase reimbursement payments to providers who use EMRs and also offer technical assistance in implementing EMRs in medical offices. When Medicaid providers implement EMRs, the state will save money, administrative burdens will be decreased, and provider participation and satisfaction will be improved.

Community Health Records

Web-based community health records (CHRs) are an inexpensive, effective tool for healthcare providers. CHRs can be an important first technological step in providing a more transparent Medicaid system that communicates between providers and the state. The information received through the CHRs is vital in the delivery of quality care. Based off the claims process, CHRs provide necessary information to healthcare providers through the internet. Since CHRs are based on the claims process there is no additional work added to the physician's schedule. Additionally, CHRs do not require additional technology beyond the internet. This is a great savings advantage to the provider and the state. CHRs also allow providers to view a patient's medical and prescription history. The information provided through the CHRs follows the patient and allows providers to deliver the best care, at the right time.

The Commission recommends the state support providers who implement community health records in their offices. The state should increase payments to providers who use CHRs in their offices. The information provided through CHRs can reduce waste, fraud and abuse while also assisting in the delivery of quality care.

Personal Health Records

The more information provided to participants and providers increases transparency and the overall quality of care. The Commission believes that participants should be more aware of the care they are receiving and their overall health status. This information will allow participants to make better, more prudent decisions regarding their healthcare. This can reduce over utilization and cut down on costs to the participants and the state. Personal health records allow participants to check and track their health status from their homes or other remote access areas such as a public library. This technology is vital in providing necessary information to patients who are trying to manage their care. This internet based technology allows patients to get prescription information, health status, physician information and additional knowledge on disease management.

Additionally, this technology allows more transparency in the healthcare system. As indicated earlier in this report, transparency of cost and quality is vital in a truly reformed Medicaid program. Personal health records are a tool that can increase transparency, while also increasing the overall quality of care. The Commission recommends that

providers implement personal health records as part of their overall technological packages. Personal health records can be implemented as part of the community health record and the electronic medical records system. Empowering individuals to take charge of their own health is essential in a truly transformed Medicaid program that protects the most vulnerable.

E-Prescribing

E-prescribing is another tool that can improve the quality of healthcare. E-prescribing enables a healthcare provider to check the following:

- medication side-effects due to drug interactions
- prior-authorization requirements
- the patient's prescription history
- the cost of the prescribed medication

This simple technology creates better communication between the prescribing physician and the pharmacist. Therefore, pharmacists no longer have to call the doctor to confirm a prescription due to an illegible script. The technology also informs the provider of any prior-authorization requirements before the medicine is prescribed. A patient's prescription history is also available through E-prescribing. Therefore, the physician will be aware of any possible drug interactions. This is especially important for patients who may not remember all the medications they are currently taking. This increases the patient's safety and satisfaction, while saving the state money and reducing administrative burdens. E-prescribing provides needed information for providers and pharmacists about a patient's prescription history. Therefore, this technology can prevent waste and abuse by participants who fill the same prescription at multiple pharmacies.

The Commission recommends the state assist Medicaid providers in implementing E-prescribing in their offices. The state should continue to work with the Division of Medical Services (DMS) pharmacy program in the implementation process for the new CyberAccessTM tool. This can be accomplished by increasing reimbursements for those providers that invest in E-prescribing technology. By doing this, the Commission believes that E-prescribing should be in all Medicaid providers' offices within five years. This will increase patient safety, decrease administrative burdens and improve the overall delivery of care.

Telemonitoring

Providing in-home services through technology is an easy and effective way to provide healthcare to a certain Medicaid population. Telemonitoring provides an opportunity for healthcare providers to deliver care to patients in the home through phone technology. This technology is most effective when used on the elderly and for case management. This allows providers to care for more patients and decreases the patient's need to visit the doctor's office. Telemonitoring decreases unnecessary visits to the physician's office by monitoring a patient's important vital signs while they remain in their home.

Additionally, it allows the physician to recommend an office visit if the patient is presenting with unhealthy vital signs.

Telemedicine

Telemedicine is another tool that physicians can use to deliver care to underserved areas. Telemedicine allows physicians to see and diagnose patients through videoconferencing. This technology enables physicians to deliver quality care to otherwise underserved areas that do not have the ability to obtain specialty care. The Commission recommends the use of telemedicine in certain fields of care such as dermatology and psychiatry. Telemedicine has proven successful in these areas and should be expanded in these areas. The Commission believes that these areas of care can be expanded to underserved areas through telemedicine.

Recommendations

There are continuing advancements in technology and the state must pursue those aggressively. The state must also continue to track innovative ideas even after reform takes place. Therefore, the state must create a Medicaid program that is able to adapt to innovative ideas and advancements.

The Commission believes that the new Medicaid program must include new healthcare technology. This can be used to improve patient care, decrease administrative burdens, and increase patient and provider satisfaction. The state must encourage providers to implement electronic medical records, community health records, personal health records, and E-prescribing, telemonitoring and telemedicine. Therefore, the Commission recommends that the state do the following:

1. Increase reimbursements to providers that implement EMRs, CHRs, personal health records and E-prescribing.
2. Emphasize that all Medicaid providers should have E-prescribing capabilities in their offices within five years.
3. Require all Medicaid providers to have electronic medical records within ten years.
4. Encourage providers to invest in telemonitoring and telemedicine.
5. Offer technical assistance for implementation of EMRs, CHRs, telemonitoring and telemedicine.
6. Enforce harsh penalties for individuals who violate privacy laws.

MENTAL HEALTH

History

Providing services and supports to individuals affected by serious mental illness and mental retardation has long been recognized as a fundamental state responsibility in this nation. Nearly every state, including Missouri, established “asylums” early in their history that, as clinical knowledge improved, were differentiated into state psychiatric hospitals and habilitation centers, and then expanded into state provided and purchased community-based services for individuals with other developmental disabilities and substance abuse and addictions. Moreover, while many government responsibilities, such as law enforcement and education, are shared with local governmental units in Missouri, local participation in the provision of mental health services is strictly voluntary through the passage of dedicated county taxes. Consequently, providing a comprehensive array of services and supports for individuals who require public mental health services is a fundamental responsibility of Missouri state government, and the Medicaid program is one of the keys to sustaining those services and supports.

After studying the public mental health system from a national perspective for the first time in more than a quarter century, President Bush’s “New Freedom Commission on Mental Health” found that:

“Today’s mental healthcare system is a patchwork relic – the result of disjointed reforms and policies....[in which] responsibility is scattered across levels of government and across multiple agencies....The services system in many communities is more fragmented for children than that for adults, with even more uncoordinated funding streams and differing eligibility requirements.”³⁰

Consequently, the “New Freedom Commission” called for transforming the nation’s mental health system.

With the passage of the Children’s Mental Health Reform Act (SB 1003) in 2004, Missouri has already accepted the challenge of transforming the public mental health system. This legislation mandated the creation and vehicle for developing a transformed Comprehensive Children’s Mental Health System under the leadership of the Department of Mental Health, and is also serving as the impetus and model for transforming the public mental health system in Missouri for adults.

Transformation

The Medicaid Reform Commission finds that the principles of the Mental Health System Transformation initiative in Missouri are consistent with the recommendations of the “New Freedom Commission” for reforming Medicaid mental health coverage. These principles include transforming the public mental health system under the leadership of the Department of Mental Health as the State Mental Health Authority:

- From
 - A Disability Model to a Public Health Model
 - Fragmentation to Consultation, Collaboration, and Integration
- Toward
 - Balanced public-private system capacity and local-state ownership and investment
 - Full implementation of evidence-based practices and a culturally competent and responsive system
 - Equal availability and a statewide consumer and family voice that drives decision-making and services
 - The advancement of technology to accelerate and sustain transformation

Mental Health Populations

The Medicaid Program is complex with multiple eligibility categories, and a variety of programs and service mandates and options. Moreover, within eligibility categories there are subgroups with specialized needs, and the availability of waivers further complicates the picture. This is also true within mental health.

There are three broad populations that require services from the public mental health system:

- Individuals with developmental disabilities, including mental retardation, autism, cerebral palsy, etc.
- Individuals with serious mental disorders, including children with serious emotional disorders, and adults with serious mental illnesses, including schizophrenia, bi-polar disorder, major depression, etc.
- Individuals with no, or a limited, ability to pay for basic behavioral health services (It is important to note that basic behavioral health services are nevertheless specialty services in the general healthcare delivery system).

Developmental Disabilities

At least in part as result of approved Medicaid waivers, the current Medicaid program for individuals with developmental disabilities who are eligible through the PTD category embodies many elements that should be continued and explored for expansion to other mental health populations. These include:

- The ability to provide a broad range of services and supports not generally available through the Medicaid program, including respite care, day habilitation services, supported employment, individual supported living, community-based residential services, environmental accessibility adaptations, and communications skills instruction.
- A guarantee of provider choice for consumers.

- A “self-determination” model that emphasizes personal responsibility and control.
- A significant local investment in, and control of, services and supports through county developmental disability mill tax boards.
- The use of care management technologies, including case management, utilization review, and having a “medical home” through the MR/DD regional centers.

At the same time, this system of care faces several challenges. There currently is an over-reliance on state operated residential services. There are opportunities for the private sector to provide services currently directly provided by the state. As more consumers access community-based programs, there is an increased need for adequate quality assurance mechanisms, and improved information to assist consumers and families in choosing among providers. There must be appropriate incentives to encourage self-sufficiency and employment while assuring continued coverage for needed services.

Serious Mental Illness and Emotional Disorders

The current Medicaid program for individuals with serious mental illness or emotional disorders who are eligible through the PTD category embodies several elements that should be continued. Children and youth with serious emotional disorders are more often eligible for Medicaid as part of the TANF population or because they are in state custody. However, their service, program, and system needs are consistent with those of the PTD population.

These include:

- The use of care management technologies, including aggressive case management, and having a “medical home” through the DMH Administrative Agents and Affiliates.
- A commitment to a Recovery Model that promotes personal responsibility and independence.
- Incorporation of evidenced based practices, such as Systems of Care for Children and Youth, a Recovery Model for adults with serious mental illness, and the Assertive Community Treatment model.

At the same time, this system also faces challenges with significant fragmentation, with responsibilities and resources scattered across state agencies. Individuals and families have difficulty accessing the services and supports they need.

There may be efficiencies and additional federal resources that could be gained through collaboration and/or integration. Several services and supports that are essential to maintaining individuals with serious mental illness or emotional disorders in their own homes or in community settings are not currently included in the Medicaid program. The following are key areas that need improvement:

- Increase evidence based practices that are not currently included in the Medicaid program.

- Improve information to assist consumers and families in choosing among providers.
- The services provided through CMHC's and FQHC's should be more strongly linked to assure appropriate availability to both physical and mental health services, while avoiding duplication of effort.
- An increased emphasis on prevention and early identification is needed.
- Additional local investments in services and supports, and to develop mechanisms that reduce fragmentation at the local level and appropriately balance state and local control.
- Consideration needs to be given to promoting the use of new technologies, including telemedicine and electronic medical records.
- There must be appropriate incentives to encourage self-sufficiency and employment while assuring continued coverage for needed services.

Basic Behavioral Health Services

As noted above, in the general health care delivery system, mental health is a specialty. This means that even basic behavioral health services (such as time-limited counseling services; the full range of substance abuse treatment services from detoxification through residential treatment and outpatient services; and medication management for conditions, such as situational depression, that, if appropriately treated, are not likely to result in permanent and total disability) are often accessed only through a referral from a primary care physician.

Unfortunately, because of the history of the development of behavioral health care, behavioral health services are often not as well integrated with primary care services as other health care specialties. So, for example, in most managed care systems, basic behavioral health services are carved out for management by a separate managed care entity.

In Missouri, basic behavioral health services for Medicaid recipients are provided through two separate mechanisms: MC+ and the Fee-for-Service system. The MC+ program has improved availability of basic health care, including behavioral health care, for many individuals and families. However, some issues require attention in the both MC+ and Fee-for-Services programs including the following:

- When MC+ was initiated, availability of substance abuse treatment for women and children was dramatically curtailed by the managed care organizations. As a result, the alcohol and drug abuse CSTAR program was carved out of MC+.
- Some individuals who are enrolled in MC+ require specialty mental health services not available through MC+.
- Reimbursement rates for some services in the Fee-for-Services system are inadequate to assure the availability and accessibility of basic behavioral health services.
- Both MC+ and Fee-for-Services basic behavioral health services should be viewed as part of the larger public mental health system and so subject to the

same standards of quality of care, incorporate evidence based practices, and promote healthy lifestyles, prevention, and early intervention.

Recommendations

The Medicaid Reform Commission acknowledges that the systems of care for these populations must reflect their unique needs, and therefore the Commission recommends that the state do the following:

1. As the State Mental Health Authority, the Department of Mental Health (DMH) leads the initiative to identify and evaluate the mental health responsibilities and resources scattered across state agencies with the goal of identifying efficiencies and additional federal resources that could be gained through collaboration and/or integration.
2. Continued collaboration between the Department of Social Services (DSS) and DMH in support of Medicaid waivers to assure that an appropriate array of services and supports are available for individuals with (1) developmental disabilities and (2) serious mental illnesses or emotional disorders who are eligible through the PTD category.
3. DMH continues to promote local investment in services and supports by county developmental disabilities mill tax boards.
4. DMH develops provider profiling approaches that give consumers and their families adequate information to make informed decisions in selecting providers.
5. The state departments collaborate to assure that evidenced based practices are readily incorporated in Medicaid behavioral health programs.
6. The state continues to employ care management technologies that promote efficiency and consumer choice without inappropriately restricting availability.
7. Implementation of a pilot coordinated care program by DMH for individuals with serious mental illnesses.
8. Support approaches to strengthening the linkages between federally qualified health centers and community mental health centers.
9. Support a public health approach that emphasizes prevention, early intervention and integration of primary care with basic behavioral health services.
10. Support local investment in mental health services and supports, and to develop mechanisms that reduces fragmentation at the local level and appropriately balance state and local control.
11. Promote the use of new technologies, such as telemedicine and electronic medical records, as appropriate for mental health services.
12. Continue collaboration between the Department of Health and Senior Services DSS, and DMH to assure that the health promotion initiatives of the MC+ plans are coordinated with the state's overall initiative to create a culture of health and that specialty mental health services are readily accessible to MC+ enrollees who require them.
13. Ensure that DMH is responsible for establishing appropriate standards of care.
14. Incentives are developed to promote expansion of employer sponsored benefit plans that include coverage of basic behavioral healthcare.

LONG-TERM CARE

Long-Term Care

The number of elderly who may be in need of long-term care is expected to increase dramatically in the next 15 years as baby boomers begin turning 65. Missouri ranked 14th in the nation in the year 2000 in the number of residents 65 years and older with a population of 755,379 within that demographic.³¹ By the year 2025, 19.8% of Missouri residents are projected to reach 65 years of age or older.³² Today, the elderly comprise 8.2% of the Medicaid population, but account for nearly a quarter of Medicaid spending in Missouri.³³ Long-term care services for the elderly in nursing homes or through in-home services account for nearly \$842 million of the \$1.2 billion spent by the Missouri Medicaid program on the elderly.³⁴

The federally-funded Medicare program which provides healthcare to individuals aged 65 and older does not include a benefit that subsidizes extended long-term care for its participants, so Medicaid has become the sole source of publicly-supported financing for long-term care. Based on current projections, the costs of providing long-term care to Medicaid recipients will continue to increase exponentially. The Medicaid Reform Commission was charged with examining strategies for controlling the increasing cost of providing long-term care for Medicaid's elderly participants. The Commission met at the Alexian Brothers PACE Project in St. Louis, Missouri on August 31, 2005 and heard testimony from providers across the continuum of long-term care about the challenges faced by the industry in meeting the needs of individuals in long-term care.

Care in the Least Restrictive Environment

The U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.* held that the Americans with Disabilities Act prohibits states from unnecessarily institutionalizing individuals with disabilities and from failing to serve such individuals in the most integrated setting in which their needs can be met. The Americans with Disabilities Act does not contain any age restrictions so the decision applies to elderly individuals as well as younger adults and children. The precedent established in *Olmstead* has led Missouri and other states to look at ways of providing long-term care to elderly residents in the least restrictive environment possible. This move toward home based services also reflects the desire of many seniors to stay in their own homes and receive care as long as possible. In addition to honoring the wishes of seniors to stay in their homes, in-home care is often much less costly than institutional-based care. In many cases, in-home services cost as little as 1/6th the cost of nursing home care.

Single Point of Entry

One of the challenges of navigating an increasingly complex system of care for long-term care is determining an individual's needs and how to best serve those needs. Not all elderly individuals who need long-term care need to have that care provided in a skilled

nursing facility. However it is important that the needs of individuals are assessed consistently and that individuals are given information about all of the long-term care options that are available and appropriate.

Providers of both skilled nursing care and in-home services generally agree that there should be a single point of entry or centralized gatekeeper for the long-term care system. Such a system would allow patients to be fully informed of the long-term care options available to them, and they would be able to move between levels of care with a minimum of administrative barriers. A system that employs a single point of entry should focus on providing care for individuals in the least restrictive setting possible, and should recognize the importance of evaluating the needs of each individual. A single point of entry should also provide information about all long-term care options to individuals along with an assessment of the individual's needs in order to help the individual and his or her family choose the care setting that is most appropriate based on that individual's needs. A single point of entry system would also create a standardized assessment system throughout the state, so that needs are assessed consistently. It would also facilitate the use of information technology to assess individuals and to examine trends about their needs and how they access long-term care.

Division of Assets: Married Couples and Medicaid Eligibility for Long Term Care

The Medicare Catastrophic Coverage Act of 1988 required state Medicaid programs to enact provisions to prevent spousal impoverishment when one spouse remains in the community and the other spouse becomes institutionalized. Division of assets allows an institutional spouse to be admitted to a nursing home while not impoverishing the spouse who stays at home, also known as the "community spouse." Division of assets is determined by an assessment that is conducted in the month that the institutionalized spouse enters the institution in a Medicaid certified bed and is expected to be there for at least 30 days.

Division of assets is a compilation of all the assets the couple currently owns. All exempt assets are transferred to the community spouse including a car, home, and an irrevocable prepaid burial plan. The non-exempt resources are then divided in half, and the community spouse is entitled to one-half of the non-exempt assets or up to the annual maximum Community Spouse Resource Allowance (CSRA).³⁵ The CSRA was originally set by federal law and is adjusted annually based on the Consumer Price Index.³⁶ For 2006, the maximum CSRA is \$99,540, and the minimum is \$19,908.³⁷ If one-half of the assets do not equal at least \$19,908 for the community spouse, income from the institutionalized spouse is deemed to be available to the community spouse to reach that level. If the income of the institutionalized spouse does not bring the community spouse to the minimum CSRA, then assets can be deemed available to the community spouse from the institutionalized spouse. This method of deeming income available from the institutionalized spouse to the community spouse before deeming assets available is known as the "income first" method. Twenty-seven states, including five of the eight states surrounding Missouri use the income first methodology.³⁸ The

community spouse's share may also be adjusted to meet the Community Spouse's Monthly Income Allowance (CSMIA), the Minimum Monthly Maintenance Needs Allowance (MMMNA), and excess shelter expenses. The community spouse can also request additional income and assets in hardship circumstances. After all of the adjustments are made, the institutional spouse must spend down any assets that remain in his or her share to \$1,000. Medicaid covers medical care, plus the cost of the nursing home for the institutionalized spouse.

Individuals who are receiving home and community-based services paid for by Medicaid have a monthly income limit of \$965. This income limit is only applicable to the individual needing the services. Home and community based service recipients also go through the division of assets described above, and then the asset limit is \$ 1,000 for the person needing services.

Licensure and Oversight

Licensure and oversight of long-term care facilities and providers of home and community based care is critical to ensure that after consumers make a decision about the most appropriate level of care for themselves or their loved ones, the care they receive is of the highest quality. Therefore it is important to ensure that there are appropriate requirements for licensure and appropriate levels of oversight for all participants in the long-term care continuum to ensure high quality, safe services.

Licensure and oversight of long-term care is another area in which technology could be utilized to help manage care and plan for the future. Information technology could be used to facilitate screenings, assessments, and health record keeping for long-term care consumers, which could in turn be used to manage the care of an individual as they move across the continuum of long-term care. Technology could also be used by the Department of Social Services and the Department of Health and Senior Services to determine eligibility and to maintain information about individuals in order to forecast future needs for the population and develop better plans to meet those needs.

Acuity Based Reimbursement

In Missouri, nursing homes are reimbursed for the care they provide based on a reimbursement system developed by a task force commissioned in 1993 and implemented in 1995. The intent of this reimbursement system was to emphasize quality patient care. It classifies expenses into one of four cost center components. These cost center components are patient care, ancillary, administration, and capital.

- ❖ The patient care cost center accounts for expenses related to direct patient care, and includes supplies, nursing services, and dietary costs.
- ❖ The ancillary cost center captures services that support patient care, such as physical therapy and laundry services.
- ❖ The administration cost center includes fixed expenses related to the overall administration of the facility.

- ❖ The capital cost center includes expenses related to the ownership of the building and is calculated using a fair rental value system rather than actual costs.

Each cost center has a ceiling set at 120% of the component median for patient care and ancillary centers and at 110% of the component median for the administration center. The ceiling for the capital cost center is fair rental value. The administration and capital cost centers are also subject to an 85% minimum utilization adjustment. Missouri's reimbursement system does not take into account the acuity of patients in the facility when determining reimbursement rates. A national survey of nursing home reimbursement rates indicated that in 1998, 33 states took acuity into account when determining nursing home reimbursement rates.³⁹ Acuity based reimbursement or reimbursement based on the level of care required by residents truly focuses the calculation of a facility's reimbursement rate on the quality of care, and creates a disincentive for facilities to "cherry pick" the least sick patients.

Long-Term Care Insurance

The elderly are the biggest consumers of long-term care but they should not be the sole focus of long-range, long-term care reforms. Long-term care insurance is increasingly becoming available, and is generally less costly for younger consumers. Missouri currently has an income tax deduction for long-term care premiums. Increased information and outreach efforts to educate consumers could be targeted at younger consumers to facilitate an understanding of the importance of long-term care planning and to educate them about options available in the purchase of long-term care insurance. The state should also examine the development of a mature long-term care insurance market that, with appropriate oversight, provides quality, actuarially sound products to consumers. The state should examine other financial tools to assist in long-term care planning.

Another way to encourage the purchase of long-term care insurance by consumers is to examine opportunities to take advantage of the federal long-term care partnership program. This program, which currently operates as a pilot project in only 4 states, makes special provisions in state Medicaid eligibility guidelines for long-term care for individuals who have long-term care insurance. It provides a "safety valve" allowing individuals with long-term care insurance to qualify for Medicaid-funded long-term care if they exhaust their long-term care insurance policy benefit, even if they do not meet the financial eligibility guidelines for Medicaid.

Recommendations

The number of elderly who may be in need of long-term care is expected to increase dramatically, and the costs of providing long-term care to Medicaid recipients will continue to increase exponentially. The Medicaid Reform Commission was charged with examining strategies for controlling the increasing cost of providing long-term care for Medicaid's elderly participants. Therefore, the Commission recommends that the state do the following:

1. Increase education and outreach efforts to encourage the purchase of long-term care insurance, particularly for younger consumers.
2. Examine opportunities to participate in the federal long-term care partnership pilot project.
3. Create incentives or requirements when appropriate for individuals to try in-home care before seeking care in a nursing home.
4. Create a mechanism that educates and informs consumers about all of their options for receiving long-term care.
5. Examine new community-based options and expand the PACE model to other sites in the state and encourage cooperative agreements between all long-term care providers to encourage and promote appropriate options for consumers.
6. Examine the pathway to safety issue to encourage safety and the placement in the least restrictive environment.
7. Examine the use of division of assets for home and community based services for individuals under the age of 63.
8. Establish a single point of entry that includes a statewide-standardized assessment, evaluates the needs of the individuals and provides information about all long-term care options that are available.
9. Review licensure and oversight requirements for all types of long-term care providers.
10. Utilize technology to better manage information about long-term care consumers and plan for future needs.
11. Explore and implement quality control indicators and oversight for licensed Home and Community Based Care providers.
12. Revise the Medicaid nursing home reimbursement system to take into account the acuity of the residents in the facility.
13. Offer and educate state employees on the importance of obtaining Long-Term Care insurance.

PHARMACY

History

The fee-for-service pharmacy program implemented cost containment measures starting in 2002 aimed at both encouraging appropriate drug use and controlling escalating expenditures. The enhancements have included the following:

- Real-time online pharmacy claim editing process called SmartPA™
- Preferred Drug List with Supplemental Rebates
- Disease Management Program
- Case Management Program
- Preferred Diabetes Testing Supplies
- Continuation of aggressive state Maximum Allowable Cost (Missouri MAC)
- Adjudicate physician drug claims to collect rebates
- Prior Authorization of all new drugs
- Prior Authorization of specific classes
- Pharmacy Provider Tax
- Introducing web-based prescribing to physicians / clinics through the CyberAccess™ tool
- Retrospective DUR (general and for behavioral health drugs)

SmartPA

The SmartPA™ clinical and fiscal editing program allows the Division of Medical Services (DMS) pharmacy program to interface individual patient claims history with a prescription drug claim submitted real time (called point of service or POS). The claim is edited for appropriate payment of the claim. Appropriateness can include a specific diagnosis that justifies the drug use, the trial of another first line drug, or other factors such as patient age or gender. This process happens within seconds, allowing the pharmacy to receive payment or denial while the patient waits for their medication to be filled. A help desk may be contacted when the provider needs to provide additional information for the claim to be paid, and if the criteria are met, the approval is provided while the doctor or pharmacist is on the phone. Missouri's Medicaid program was the first to implement this automated claim "review" process on a large scale, and for the most recent fiscal year, has achieved an annualized off-trend savings of \$955 million. This has allowed a significant decrease in the pharmacy budget trend since implementation.

Preferred Drug List

The Preferred Drug List (PDL) and Supplemental Rebates allows for certain drugs within a class to be "preferred" when the drug manufacturer has negotiated a supplemental rebate to the state that makes their product more cost effective than the others in that class. Thorough clinical reviews are performed preliminarily to assure that the preferred products are equally effective and safe as the others in the same class. Other non-preferred products become available only based on individual patients meeting specific

medical criteria for their approval. This process has resulted in savings of \$250 million annually.

Disease Management

The Disease Management program uses a pharmacist - physician team concept to engage patients in more effective self-treatment and education about their disease state. The first year evaluation has demonstrated very positive results, both in patient health and financial status. For patients enrolled in the program, there was a 3.8% decrease in the number of hospitalizations, 10.3% decrease in emergency room visits, and 7.6% decrease in per member per month medical costs over the first four quarters of the program. Summaries of patient encounters with their Disease Management providers indicate improvement in disease state (improved medication compliance, pain control, etc.) An adjusted annualized per member per month savings of \$277,361.04 was achieved for fiscal year 2003.

Case Management

The Case Management program has operated on a smaller scale of around 200 patients in southwest and southeast Missouri who are concomitantly using nine or more medications per month and/or are high utilizers of hospital services and meet certain other eligibility criteria. Case Management is designed to address healthcare needs of patients who have more complex medical conditions requiring more intensive telephonic intervention with a nurse care manager. Quarterly outcomes have been very positive, and the department is anticipating finalization of the first annual outcomes report in the near future.

Chronic Care Improvement Program

With the preliminary Disease Management and Case Management results on cost savings and clinical outcomes, the Department of Social Services is encouraged about the upcoming Chronic Care Improvement Program (CCIP) still in the proposal stage that will help achieve even more in patient quality of care and overall fee-for-service Medicaid program savings over time. The CCIP is basically an enhanced primary care case management program incorporating the tenets of disease management, care coordination and case management into a patient base selected by a risk assessment model. In addition to telephonic care coordination, those patients with more serious and complex disease states will receive in-home care coordination services (around 20% of those served). Providers will also have web-based access to their patients' health data (similar to the information described below) with the ability to input additional data following each patient encounter. This patient medical history will be exceedingly helpful to providers in determining the course of treatment, including prescribing medications.

Maximum Allowable Cost (Missouri MAC)

The Missouri MAC pricing process has been in place for many years. This process automatically limits pricing of most generically available trade name products to a widely available equivalent generic price. If a claim for a trade name product is entered into the Medicaid point of sale system by the pharmacy, the system will respond with the MAC pricing information, so the pharmacy is aware of the pricing limitations. In most cases, prescribers are willing to allow generic substitution and indicate such on the prescription.

Products with MAC pricing may only be dispensed as a trade name product if prior approval is received. Prior approval is only given when medical information supporting the patient's need for the trade name drug is received in advance by the prescriber. In effect, this process substantially limits Medicaid reimbursement to generic products. There are, however, instances in which the state's receipt of manufacturer supplemental rebates makes the brand product less expensive than the generic counterpart. In either case the pharmacy program closely observes these opportunities for maximizing state savings.

Behavioral Pharmacy Management

In addition to the efforts mentioned above, the Comprehensive NeuroScience (CNS) Behavioral Pharmacy Management System (BPMS) employs a retrospective drug use review process based on evidence-based "best practice" guidelines. This process seeks to improve the quality of behavioral health prescribing practices, improve patient compliance with therapies, and reduce behavioral health drug spend trend rates. Intervention letters are sent to prescribing physicians alerting them to their patients' duplicative therapy or other potential inappropriate usage of antipsychotics, stimulants, antidepressants and mood stabilizers (anticonvulsants, Lithium). Interventions are repeated over time to reinforce appropriate prescribing.

This program is accomplished through collaboration between the Missouri Department of Social Services, Department of Mental Health, and a contract with CNS. Missouri was one of the first states to implement such a program, and thus has achieved demonstrable improvements in behavioral health drug trends. Mercer Human Resource Consulting was engaged to provide an independent evaluation of the impact of CNS interventions to address Medicaid behavioral health drug expenditures. The evaluation provided the following observation: Using the actual second quarter from 2003 over the first quarter from 2003 trend as a baseline for growth, Mercer estimates that a 1% reduction in the quarterly trend rate would have reduced Missouri Medicaid's antipsychotic, stimulant, antidepressant and mood stabilizer product costs by over \$8 million over the next four quarters. This assumes that the baseline trend rate remained constant over the same four quarters.

In addition to the current BPMS program and the emerging Medical Risk Management Program, there are additional offerings targeted at best practices and management for patients including: a program for patients with ADD/ADHD; a program to monitor and encourage best practices in bipolar disease; and a project only now under development to encourage patient medication adherence that should result in a reduction in hospital and emergency room visits in patients with severe mental illness.

Web-based Prescribing

Areas of discussion that focus on holistic prescribing, disease management, and ability to reduce patient misuse will also be addressed by the new CyberAccessTM tool that is on the brink of being introduced to the prescribing provider community. This tool will allow electronic, web-based access to the provider's patient claim information, incorporating paid Medicaid medical and pharmacy claim data into a patient profile. Providers will be

able to review patient utilization of services, including medications and services from other providers, diagnoses and procedures, all in a comprehensive listing in chronological order. In addition, a feature that is anticipated to interest providers is the ability to select a medication for their patient and immediately determine whether it will be reimbursed by Medicaid without limitations such as prior authorization or clinical edit. If such a limitation is in place, the provider may request an override via the electronic tool itself, and eliminate the need for a phone call or fax request.

This enhanced prescriber interface will also allow the program's first entry into e prescribing. After the above process assists in selecting the best and most appropriate product, the prescriber may initiate an e prescription that will be forwarded to the pharmacy of the patient's choice. As this process matures in prescribers' practices, total e prescribing will be possible.

Medicare Prescription Drug Program – Part D

Finally, during 2006 over half of the expenditures of the pharmacy program will be transferred to the new Medicare Prescription Drug Program. Because of the structure of the state mandated participation (Clawback) an increased cost will be realized by the state. However, the prescription program only represents approximately 30% of the total state expenditures for these "dual" patients. The Division should be diligent in monitoring the outcomes experienced by the patients after this transfer and make every effort to continue to receive the prescription utilization information. This will be important because the state must continue to manage the healthcare of these individuals to preclude greater out-year cost while also maintaining or improving the patients' current healthcare status. The prescription drug data is one of the best surrogate markers for outcome study.

Recommendations

The enhancements already in place have helped to maintain Missouri Medicaid pharmacy program growth to about a 10.5% annual increase as opposed to the national pharmacy trend of about 13.5%. Individual prescription prices have been held to less than a 4.5% increase as opposed to the national trend, which currently exceeds 7%. Additional efforts focused on coordination of care emphasizing prevention of disease progression, and efforts to assist providers with improved patient care and medication prescribing, should contribute to even greater success in holding or diminishing healthcare cost increase trends. Therefore, the Commission recommends that the state do the following:

1. Continue and enhance the collaborative efforts of the Division of Medical Services and the Department of Mental Health through their common partner Comprehensive NeuroScience.
2. Continue to expand and update preferred drug and supplemental rebate opportunities.
3. Enhance current and develop additional clinical and fiscal on-line edits.

4. Improve and expand step therapies as supported by best practice and current medical evidence.
5. Update and expand MAC pricing of generically available products.
6. Expand cost avoidance through required third party billing.
7. Support targeted prior authorization with as much transparency as possible.
8. Support the inclusion of new technology as it becomes available especially in the areas of electronic prescribing and electronic medical records.
9. Continue maximizing other processes already in place that ensure maximum cost containment and appropriate drug usage based on best practices and current medical evidence.

All of these program management and reimbursement limitations are geared toward maximizing state savings while ensuring appropriate medication prescribing and usage, and attempting to avoid unnecessary bureaucratic burden for providers. As the technology has become available, automated processes have been put in place to allow providers greater ease in prescribing appropriately for their patients.

IMPROVING AVAILABILITY OF QUALITY CARE

Making quality care easily available for Missourians encompasses the dual concepts of both the delivery of care and the need to provide healthcare for vulnerable populations. The vulnerable populations include those individuals who are low-income and are high-risk individuals with no real opportunities to obtain quality healthcare. This section will address those dual concepts.

Delivery of Care

The Commission recognizes the problems with the current Medicaid system. As already discussed in other sections of the report, particularly in the provider participation and satisfaction section, there are numerous problems with the administration of care such that it imposes burdens upon, and allows for noncompliance from, both the providers and the participants. To that end, one primary theme that has emerged from meetings and testimony is the need for a medical home for the participants.

The medical home is where a Medicaid participant could obtain his or her medical care on a regular basis and it would allow the healthcare provider and the participant the opportunity to get to know each other better over time. In addition, assistance is provided to the participant to navigate the complexities of the system. A medical home would enhance continuity of care and improve the medical care received, particularly primary care services. Today, with the ad hoc availability to jump from provider to provider, there is no incentive for either the provider or the participant to promote and follow best practices for healthcare.

Further, the assignment of a medical home would reduce the cost of non-emergency healthcare and save valuable taxpayer dollars. Primary care services could be used to ensure preventive measures are followed and help participants maintain healthy lives. By requiring a participant to undergo a physical examination, not for eligibility determinations, but as part of the availability of the medical home, participants could concentrate on wellness and disease avoidance.

The state should explore how best to implement a medical home through the assignment of a primary care physician for the recipient. Changes enacted by the Balanced Budget Act of 1997 allow states to implement primary care case management to Medicaid participants in a fee for service setting without the need to apply for a waiver and only a need to submit a state plan amendment.

Primary care case managers (PCCM) may be physicians, physician group practices, FQHCs, or other providers such as nurse practitioners or physician assistants. Also, the state could require mandatory enrollment in primary case management. In addition, reimbursement to PCCM providers may be under fee-for-service, capitation, or other approved methodologies.

Delivery of care could also be improved by educating participants on the proper utilization of care. There are pilot programs, particularly one in Illinois, where Medicaid participants are enrolled in patient education classes. Pertinent information provided through education and the primary case manager would empower the participant and shift the focus of his or her care from the emergency room to primary care.

Uninsured

As noted above, the Commission recognizes that reforming the Medicaid system cannot be done in isolation and without acknowledging the need to address the uninsured. Missourians without health insurance constitutes a grave public policy concern for the state. As discussed in other sections, findings from the 2004 Missouri Health Insurance Coverage and Access Survey, conducted between March 2004 and July 2004, show that the overall level of chronically uninsured in Missouri, across all age groups, was 8.4 percent or approximately 463,000 individuals.⁴⁰ However, there is a significant number of Missourians that may be temporarily uninsured due to temporary unemployment or seasonal employment. Higher private insurance premiums and soft labor markets in the last few years have caused the number of uninsured to increase. Again, testimony during the hearings echoed themes of continuing to promote projects that are leveraging public and private dollars, such as the use of community health centers as safety net providers and implementing innovative insurance reforms.

Federally Qualified Health Centers

The Commission toured the facilities at Swope Health Services in July 2005, a federally qualified health center (FQHC). The FQHC model is one that incorporates grass-roots energy, evidence-based care and population-based care management. FQHCs are federal, state and local initiatives, which can be not-for-profit or public entities. The centers provide primary healthcare, maternity and prenatal care, preventive care, some emergency care, and pharmaceutical services for participants of all ages. They are part of a federal grant program authorized by section 330 of the Public Health Services Act and reauthorized under the Health Centers Consolidation Act of 1996. FQHCs include Community Health Centers, Migrant Health Centers, and HealthCare for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers. Rural Health Clinics also offer needed assistance in the underserved areas of the state. In many rural areas these rural health clinics serve much of the same functions as FQHCs in providing availability to healthcare.

Only 28 percent of an FQHC's budget is derived from federal grant support. The remaining revenues are comprised of patient charges (6%), state/local grants (7%), Medicaid (40%), Medicare (5.1%), and commercial insurance (5.4%).

In the past few years, FQHCs have increased the number of sites by over 30 percent, dental encounters by 140 percent, medical encounters by 20 percent, and increased uninsured and Medicaid users by 18 and 50 percent, respectively.⁴¹

In an effort to decrease the number of uninsured, the state needs to assist communities in starting or expanding FQHCs through technical assistance for the grant process.

Dental Care

Dental care is like any other healthcare, it must be maintained. Lack of insurance leads to lack of the availability of appropriate dental care. According to the Missouri Dental Association, approximately 600,410⁴² persons are eligible for dental services to be reimbursed by Medicaid. Further, eighty percent of all decay found in the United States will be found in this population. A survey conducted by the Missouri Dental Association revealed that the private care dental network is operating at approximately eighty percent capacity, and sixty-five percent said they could take adult Medicaid patients into their practice with sixty-seven percent saying they would dedicate ten to twenty percent of their practice to these clients.

The Commission heard from Heartland Health out of St. Joseph and from the UMKC Dental School about the partnership they have created. The Dental Project provides screenings to children in Kindergarten through 3rd grade through a mobile clinic. These screenings have resulted in fewer emergency room visits and an increased school attendance. In February 2002, Heartland also partnered with local FQHCs to open a permanent dental clinic. In addition, UMKC has started sending dental students to perform their rotations in the state's FQHCs and has promoted various community service projects. The theme from such testimony was that funding and facilitation of similar partnerships throughout the state would help with availability of healthcare.

An option to increase availability to dental care is to carve-out dental care from the coordinated care program. The Department of Social Services would establish a statewide uniform dental program and contract with a single source private entity to provide dental program management service coordination. This proposal would provide a single-program administrator to deal with dental providers. With a single payer contracting with the state, there will be one large panel of providers all receiving reimbursements from the same entity, under the same guidelines, and using the same reimbursement rate. This would eliminate costs, streamline the system and help increase the number of participating providers.

Insurance Reform

The state must help the working poor access private insurance and help those receiving public medical assistance to transition to private health insurance as well. Studies reveal that between 78 percent and 85 percent of employees sign up for health insurance when it is offered from an employer.⁴³ Therefore, work-based enrollment is one of the most effective tools for insuring people.

The state should look into expanding employer-based coverage by providing affordable coverage to small businesses and the employees. This could be accomplished through premium assistance, public and private coverage and reinsurance. The reinsurance

program would cover a portion of the private insurer's claims as a way to prevent catastrophic claims from overwhelming the small employers.

The state could also continue to explore allowing small business and uninsured employees to buy into the state-employee health plan, Missouri Consolidated Health Plan. Currently, the Department of Health and Senior Services is in the third year of a grant entitled, the Missouri State Planning Grant (MSPG), and is exploring such options.

Small Employer Groups

The last several years, employers experienced increases in health premium. To accommodate these increases, employers raised the employee's cost share (deductibles, co-insurance) and modified the benefits available. As the economy remains sluggish and costs continue to rise, employers address the crisis by removing retirees from coverage, dropping health coverage all together or opting for a limited coverage policy (such as disease specific or health discount plans) leaving the employees drastically underinsured and financially vulnerable in most cases.

For most small employers, having one employee with a moderate health condition drastically impedes their ability to obtain affordable, comprehensive healthcare coverage.

Tax credits for health insurance

Tax credits for small employers can help small businesses to not only afford the high cost of health insurance, but also to recruit and retain valued employees. Additionally, if refundable tax credits are implemented, small businesses can use it to receive a tax refund if they do not owe taxes for the year.

A tax incentive could be implemented to encourage employers to offer health plans. Employers are encouraged to provide the employees with a defined contribution towards the purchase of the members choosing. The state should look into an employer tax credit that would be available for all employer-offered health insurance as it could be more broadly effective.

The Commission also recommends instituting a combination of individual healthcare tax credits and tax credits for small employers. By combining such credits with funding to create purchasing pools, much assistance would be given to low-income working participants to allow them to obtain health insurance. The efficacy of tax credits to increase coverage and stabilize rates should be studied.

Associated Health Plans

Associated Health Plans (AHPs) are groups of small employers that band together and purchase health coverage. These associations are also known as health purchasing alliances, health insurance purchasing coalitions, group purchasing agreements or Multiple Employer Welfare Associations (MEWAs). AHPs differ from one another in their structure and operation, with some existing under state insurance regulations while others do not. AHPs can be privately managed or run by a state agency. Some AHPs can

be established only through legislation, while others are formed by associations of employers without legislative action.

An example is the new AIMCare product announced in October by Associated Industries of Missouri. To provide health insurance to all employer members of at least 2 members, Associated Industries created a trust. Employers pay a membership to Associated Industries to qualify for applying. Any employer group insured under the trust pays premiums based on the entire trust membership's claim experience, not the individual employer group. MEWAS are allowed under Missouri insurance laws if the multiple employer trust is established for insurance purposes and allows for and sets parameters for establishing associated health plans.

Although research and experience show that plans such as these will not work unless employers have no choice but to get coverage through a multi-employer group, the groups are well regulated, or the insurance sold to them is well regulated. If employers have the option to purchase coverage outside the group, insurers assume that only bad risk employers will be in the group because a good risk employer could get better rates on their own.

The Commission recommends looking into whether a law should be established that the specified employees can get insurance from these groups but cannot get it on his or her own. MEWAs in the mid 1980s and early 1990s operated outside any effective regulation and a great deal of problems ensued. Updates to the current laws would be required including a law establishing the criteria for MEWAs seeking to purchase fully insured plans.

The Missouri Department of Insurance recently met with the Southwest Area Manufacturer's Association and Mercy Health Plan to discuss the ability to create a consortium for rating purposes. The department approved this request. Monitoring of and using this consortium as a pilot program would be very valuable to employer groups.

Missouri Health Insurance Pool

Missouri Health Insurance Pool is the state's high-risk pool administered by Blue Cross and Blue Shield of Missouri and Blue Cross and Blue Shield of Kansas City. Such pools are typically state-created, nonprofit associations that offer comprehensive health insurance benefits to individuals with pre-existing health problems. These pools cover people who have been denied coverage in the private market due to a chronic illness or condition. Funding for the pool is subsidized through assessments on insurers or through government revenues or both.

The Missouri Health Insurance Pool is not compliant with the federal Health Insurance Portability Accountability Act (HIPAA). Qualifying the state high-risk pool would require additional state funding. The rate cap must be lowered from 200% to 150%. Making the high-risk pool HIPAA compliant will also expand coverage and therefore expand costs. Because the high-risk pool is currently not HIPAA compliant, certain federal tax subsidies are not available to Missouri consumers. For instance, the Health

Coverage Tax Credit (HCTC) provides a 65% health premium subsidy to misplaced workers under the Federal Trade Readjustment Assistance Act or some individuals who receive pensions from the Pension Benefit Guaranty Corporation. Such a program would not be available in Missouri.

The Commission notes that the issue regarding the high-risk pool has been explored and recommends against taking any action in this area at this time.

Health Savings Accounts

Health Savings Accounts (HSAs) were established in federal law December 8, 2003 when President Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003. A HSA is a new way of saving money to pay for current and future medical expenses on a tax-free basis. HSAs are tax-free financial accounts tied to an insurance policy with a high deductible of at least \$1,050 for an individual or \$2,100 for families. After the deductible is reached, policyholders receive comprehensive coverage.

There are four federal requirements to be eligible for HSAs:

1. A person must be covered simultaneously by a high deductible health insurance policy.
2. The HSA enrollee cannot be covered by any other health insurance plan, such as a spouse's plan.
3. Not be enrolled in Medicare. Medicare beneficiaries cannot contribute to an HSA. They may, however, spend money contributed to an HSA prior to their enrollment in Medicare.
4. The HSA enrollee cannot be claimed as a dependent on someone else's federal income tax return.

There are no income, employment or other age limits in the federal law. For 2006, the maximum annual HSA contribution for an eligible individual with self-coverage only is \$2,700 or \$5,450 for family coverage. The employer or the individual, or both can make contributions to HSAs. Employer contributions to an HSA are always excluded from an employees' income and must be comparable for all employees participating in the HSA. Contributions to HSAs by individuals are deductible, even if the taxpayer does not itemize.

The interest and investment earnings generated by the account are also not taxable while in the HSA. Amounts distributed are not taxable as long as they are used to pay for qualified medical expenses. HSA funds can be used to cover the health insurance deductible and any co-payments for medical services, prescriptions, or products. In addition, HSA funds can be used to purchase over-the-counter drugs and long-term care insurance, and to pay health insurance premiums during any period of unemployment.

Unlike some other types of accounts, the individual does not lose HSA funds at the end of the year. Unspent balances remain in the account earning interest until it is spent on medical care. This provides a strong incentive to spend wisely on medical care, just like

for other items that are purchased. It also encourages account holders to shop around for the best value for their healthcare dollars.

The Commission recommends providing leadership by requiring Missouri Consolidated Health Care Plan to offer HSAs to state employees.

Individual Market Plan

The Commission recommends exploring a high deductible individual health insurance plan at an affordable rate but with a certain level of benefits. The individual insurance plan would be required to provide coverage for a few specific benefits including a minimum number of visits with a primary care physician. This high deductible plan would offer a safety net for individuals who would otherwise go without coverage. The state should explore implementing the plan in a similar fashion to how the state supported Missouri Employers Mutual Insurance Company. Missouri Employers Mutual Insurance Company is a state fund that was organized in 1994 to provide a viable market for workers' compensation insurance for small and mid-sized employers throughout Missouri.

Quality

Inherent in any discussion about reform in the Medicaid system is the notion that we should benchmark our Medicaid system against "best practices" in other states. The Medicaid system is constantly evolving both on the state and federal level and so therefore the system should be constantly improving.

The Commission believes that the Division of Medical Services should participate in the Missouri Quality Award Process. The Missouri Quality Award Process, modeled after the prestigious Malcolm Baldrige National Quality Award, is recognized as one of the strongest state-level quality award programs in the country and is the official state recognition for excellence in quality leadership. By participating in the award process, DMS would engage in a thorough and objective educational evaluation. Through this evaluation DMS would learn and apply quality implementation techniques and assessment methods.

Recommendations

Improving availability to quality care for Missourians encompasses the dual concepts of both the delivery of care and the need to provide healthcare for vulnerable populations. The vulnerable populations include those individuals who are low-income and are high-risk individuals with no real opportunities to obtain healthcare. Therefore, the Commission recommends that the state do the following:

1. Assist communities in starting or expanding FQHCs through technical assistance for the grant process.
2. Ensure that all Medicaid participants have access to a Medical Home where a primary care case manager will be available to assist in their healthcare decisions.

3. Fund and/or facilitate public-private partnerships to promote the availability of healthcare, such as the examples stated above.
4. Explore a dental care carve-out program from the coordinated care program.
5. Look into expanding employer-based coverage by providing affordable coverage to small businesses and the employees.
6. Continue to explore allowing small business and uninsured employees to buy into the state-employee health plan, Missouri Consolidated Health Care Plan.
7. Institute a combination of individual healthcare tax credits and tax credits for small employers.
8. Offering a high deductible individual health insurance plan at an affordable rate but with a certain level of benefits.
9. Recommend providing leadership by requiring Missouri Consolidated Health Care Plan to offer HSAs as a choice to state employees.
10. Require the Division of Medical Services to participate in the Missouri Quality Award process.

ELIGIBILITY

Availability to the healthcare system should not be predicated on an individual's eligibility category, but on what an individual's healthcare needs are in the healthcare spectrum. The typical basic safety net package should be expanded where healthcare needs are greater. The needs of Medicaid participants vary widely according to many factors. The state must take into consideration, for example, that a permanently and totally disabled individual may require different assistance than a healthy adult with a child on Medicaid. Additionally, an elderly participant requires different assistance than a pregnant woman. The state would be giving its citizens a disservice if it did not evaluate closely the needs of those eligible for assistance.

DEHAP – Disabled Employee's Health Assistance Program

The Commission recognizes the need for a new disabled employee program that will encourage Permanently and Totally Disabled (PTD) individuals to become productive, self-sufficient, and working members of society. A new Disabled Employee's Health Assistance Program (DEHAP) should have restrictions and requirements that must be met by the PTD individual to receive healthcare assistance. The new program may consist of the following:

Asset Limit

The asset limit for the new program may be the same as the regular Medical Assistance – Permanently and Totally Disabled (MA-PTD) program, currently \$999.99 for a single person and \$2,000 for a couple with the standard exemptions.

Earned Income Test

To qualify as working for purposes of this program, it should be demonstrated that Social Security taxes are paid on the earnings. This would prohibit informal work arrangements, such as caring for a neighbor's pet, from qualifying someone for the program.

Gross Income Limit

The program could have a gross income limit of 250% of the federal poverty level (FPL) for the disabled worker and spouse, currently \$1,995 per month for a single individual and \$2,675 for a married couple. The previous program had a gross income limit of 250% of the federal poverty level for a single person (even if married), but excluded the spouse's income up to \$100,000 per year.

Net Income Limit

The same net income limit for this program should be the same as the regular MA-PTD program, currently 85% of the FPL. The previous program only had a gross income limit of 250% of the FPL.

Income Methodology

The methodology for the new program should be the same as the one for the regular MA program to determine gross income. To determine net income the following could be disregarded:

- ❖ A \$20 standard deduction. This is the same as what is allowed for the regular MA-PTD program.
- ❖ Health insurance premiums. This is the same as what is allowed for the regular MA-PTD program.
- ❖ The first \$65 and one-half of the remaining earned income of a non-disabled spouse's earned income. This is the same as what is allowed for the regular MA-PTD program.
- ❖ All earned income of the disabled worker. This would encourage a person with a disability to work, rather than penalize a person for working. In the regular MA-PTD program increased earnings result in an increased spenddown amount.
- ❖ A standard deduction for impairment related employment expenses equal to one-half of the person's earned income. This would be of more benefit to individuals with higher amounts of earned income, thus demonstrating more commitment to work. This would reward persons with disabilities trying to re-enter the workforce at the risk of losing Social Security Disability benefits, but would prevent a very high-uneared income recipient from qualifying for the program by doing only minimal work.

Premium

The state could require a monthly premium for anyone with income above the poverty level seeking to participate in this program. Under the federal Ticket to Work legislation, the state cannot charge more than 7.5% of gross income for a premium. An example of a premium structure could be set at 7.5% of the lower end of reasonable increments of income. For example, a minimum premium would be charged for persons with income below 100% of the FPL and increase at each 50% increment. For single individuals premiums would be:

- ❖ \$0 for incomes that do not exceed 100% of FPL (\$798 per month).
- ❖ \$59 for incomes between \$798.01 (100% FPL) and \$1,197 (150% FPL).
- ❖ \$89 for incomes between \$1,197.01 (150% FPL) and \$1,596 (200% FPL).
- ❖ \$119 for incomes between \$1,596.01 (200% FPL) and \$1,995 (250% FPL).

Under the previous program, premiums were not charged until income reached at least 150% of the poverty level.

Recommendations

The state should consider the needs of the individual before giving assistance to ensure that the best care is given at the right time and at the right cost. Therefore the Commission recommends the state do the following:

1. Establish a tiered benefit package based on the healthcare needs and category of the participant.
2. Maintain flexibility to allow for the appropriate use of state funds to meet the healthcare needs of Missourians.
3. Establish a Disabled Employee's Health Assistance Program (DEHAP).

OTHER STATE INITIATIVES

Missouri is far from the only state that is considering or beginning to implement Medicaid reform measures. According to a recent study, all 50 states plan to adopt and implement a wide variety of cost containment measures in FY 2005 and FY 2006.⁴⁴ The Medicaid Reform Commission had the opportunity to learn about some of these other state initiatives at various points in its deliberations. The following summaries of other state Medicaid initiatives represents a variety of ideas and practices that the Commission believes bear further study and additional monitoring. They range from comprehensive Medicaid waivers that completely reform state Medicaid programs to local public-private partnership initiatives to help small employers provide assistance with healthcare costs to their employees.

Florida

Medicaid Waiver

The Centers for Medicare and Medicaid services approved Florida's waiver application on October 19, 2005 and on December 16, 2005, Governor Jeb Bush signed into law legislation implementing the Medicaid reform changes from the waiver application. The waiver will limit spending for beneficiaries and allow private health plans to limit benefits. Initially, the program will be a pilot demonstration in Broward and Duval Counties, and after one year the program may expand to other counties with legislative approval.

The program created under the waiver is a defined contribution managed care plan, in which the state sets a ceiling on spending for each recipient. Children and pregnant women will be exempt from the state reimbursement limits. It will ultimately increase the use of Medicaid Managed Care throughout Florida, creating a capitated managed care system for 2.2 million Medicaid recipients. The program will include three categories of care: comprehensive care, enhanced services, and catastrophic care. In the comprehensive care category, the premium is expected to be sufficient to cover most services needed by most people. The premiums will be based on medical condition and historic use of healthcare. The enhanced services category includes flexible spending accounts for beneficiaries with healthy habits to purchase additional services or pay for employer-sponsored health insurance. The catastrophic coverage category begins coverage at a specified dollar amount and covers all services up to a maximum amount. Separate risk-adjusted capitation rates would be set for each of the specific population groups. The plan also allows Medicaid recipients to opt-out of the Medicaid recipients can opt-out of the Medicaid certified plans and use their premium to purchase coverage through an employer-sponsored plan.

The waiver also creates an integrated (acute and long-term care) fixed-payment delivery system for elderly Medicaid patients. Medicaid funding for services to those 60 and

older will go into the demonstration project in 2 areas in the state, and voluntary enrollment will be tested in one of the areas. Individuals aged 60 and over with developmental disabilities in the community or in the institution, and persons in that age group in AIDS, traumatic brain injury and spinal cord injury waiver programs are excluded from participation in the program.

Public-Private Partnerships: Hillsborough Health Care Program

The Hillsborough Health Care Program is a managed care plan funded by sales tax and administered by Department of Health and Social Services in Hillsborough County. The plan includes four networks providing primary care throughout the county. It covers prescriptions, vision, dental, home health, and other medically necessary services, as well as specialist care, diagnostic services and hospital services. It is designed for county residents with incomes at or below the federal poverty level that have no other medical coverage. The program also includes a Medical Crisis Intervention program, which allows individuals with incomes over one hundred percent of the federal poverty level and with no other coverage to qualify, requires co-payments based on income. It is primarily for conditions that are expensive to treat because of severity or chronic nature of the condition. Medicare recipients with low incomes may qualify for limited assistance for services such as prescription drug coverage and eyeglasses.

Illinois

Illinois began a pilot project to create local partnerships to cover uninsured individuals in 2003. These “3 share” models have been expanded to four counties and their goal is to help small employers provide health insurance to their employees. The name reflects the fact that counties, employers, and employees will share the financing of the program. The benefit package is generally less comprehensive than those offered by larger employers.

Iowa

Faced with losing its intergovernmental transfer (IGT) funding, the Iowa Legislature passed HF 841 and developed a Medicaid reform program and submitted a waiver proposal to the Centers for Medicare and Medicaid Services which was approved on July 1, 2005. The waiver uses IGT money to pay for a reform initiative, which includes an expansion of eligibility to uninsured residents with incomes up to 200% of the federal poverty level. These individuals must be between the ages of 19 and 64, and be parents of children on Medicaid, single adults, or married adults. Officials estimate that they will cover between 20,000 and 40,000 more people under the new program.

The expansion population will have different rules for their coverage than the regular Medicaid population. This group will receive a medical evaluation and personal health plan upon enrollment, and the program will include incentives for lifestyle choices like weight control and smoking cessation. Preventive care is also encouraged under the new program. Participants will be required to select a primary care physician, and in many cases participants will be required to use a nurse help line before accessing an emergency

room. Participants who follow health plans or who do not smoke will pay lower premiums and co-pays. The new group of participants will be required to pay a monthly premium equal to 5% of their salary. They will also have health savings accounts and be entitled to a credit of up to \$1000 for any Medicaid covered service.

The program includes incentives to improve the level of care and general health for all Medicaid recipients. For example, smoking cessation programs will be implemented to achieve the goal of reducing smoking among the entire Medicaid population by 10%; all Medicaid-enrolled children ages 12 and under will participate in a dental home program and receive dental screenings and preventive care; and home and community based services will be encouraged by increasing the threshold level of admission into nursing homes.

Kentucky

Kentucky submitted its waiver proposal to the Centers for Medicare and Medicaid Services on November 4, 2005. The waiver proposal features differential benefit packages, with benefits varied by population and limits on services. It includes an opt-out provision that creates a financial incentive for beneficiaries to access employer-sponsored health insurance. The Kentucky state children's health insurance program will be converted to a stand-alone private insurance program, and mental health services will be re-designed to improve care coordination. The waiver proposal includes tiered co-payments for pharmaceuticals and increased co-pays for physician and emergency room visits. It also creates "Get Healthy" accounts for beneficiaries who have certain healthy practices to purchase additional healthcare services, including gym memberships and smoking cessation programs.

Michigan

Muskegon County Michigan has a community partnership program that began in September 1999. The program helps small and mid-sized businesses provide insurance to their employees and their dependents. In order to participate, businesses must be located in the county, have a median wage of \$10 or less per hour and have not offered health insurance during the previous 12 months. The State of Michigan and the two Muskegon county hospitals agreed to allow the use of DSH funds to help finance the program. Employers and employees each pay 30%, and the community covers the remaining 40% of the costs of the program. Over 300 businesses are currently enrolled, serving 1,300 individuals.

New Mexico

New Mexico has implemented a program known as the State Coverage Initiative, whose goal is to address the state's high rate of uninsured and low rate of employer sponsored health coverage, create a public/private partnership, and offer affordable healthcare to low-income working adults through an employer-based system. The program provides low cost basic health insurance through an employer-based benefit program.

Participation is open to uninsured adults aged 19-64 with incomes up to 200% of the federal poverty level. The employer contribution is \$75 per person per month, and employees pay monthly premiums based on family income, up to \$35 per month. The benefits provided under the program include primary and specialty care, inpatient and outpatient hospitalization, prescription drugs, lab, X-ray, physical, occupational and speech therapy, behavioral health and substance abuse services. Annual benefits are capped at \$100,000, and maximum out of pocket costs are capped based on a sliding scale. Co-payments are also on a sliding scale that is based on family income. The program is open to individuals who have not dropped insurance in the last 6 months and employers who have not dropped commercial insurance in the last 12 months.

Pennsylvania

Pennsylvania's Health Insurance Premium Payment program was implemented in 1995, and it enrolled 18,000 clients (out of 1.7 million) in FY2000, and generated \$64.2 million in savings. The program uses automated processes to enroll and track participants, and the use of this automated system distinguishes Pennsylvania's HIPP program from other state HIPP programs. The electronic information allows the staff to perform cost-effectiveness analysis, generate referrals, schedule payments, and calculate savings.

South Carolina

South Carolina recently submitted its 1115 waiver proposal to the Centers for Medicare and Medicaid Services. The waiver creates a consumer-driven system where participants engage in purchasing healthcare. The program would require all beneficiaries except dual eligibles to have a personal health account to purchase a health plan. It would require meaningful co-pays, with a maximum out-of-pocket limit per family. Beneficiaries would be able to choose from one of four plans. It also includes a self-directed plan in which beneficiaries would only have coverage for major medical services, while premiums and other services would be paid from the personal health account. Individuals with positive health outcomes would receive reward cards from health and wellness product vendors.

Utah

Utah's 1115 demonstration waiver, called the primary care network began July 1, 2002. It covers individuals ages 19-64 who are U.S. citizens or legal residents, meet certain income guidelines (approximately 150% of the federal poverty level), do not qualify for Medicaid, do not have health insurance or access to health insurance, student health insurance, Medicare or Veterans Benefits, or access to health insurance at work. The program provides primary care services including primary care visits, some emergency room visits, emergency medical transportation, lab services, x-rays, up to 4 prescriptions per month, dental exams, x-rays, cleanings and fillings, one eye exam per year, and family planning services. It requires a \$50 fee and annual co-pays. The goal of the program was to provide coverage to 25,000 residents; as of September 2004, approximately 14,000 Utah residents were enrolled.

Vermont

Vermont's 1115 waiver, called the Global Commitment to Health was approved by the Centers for Medicare and Medicaid Services in September 2005. This program is a 5-year demonstration project to test the impact of a federal funding cap and state flexibility to manage services. CMS authorized a maximum of \$4.7 billion for FFY 2006-2010; Vermont's governor and legislature estimate that spending will reach only \$4.2 billion during the same time frame. If costs exceed \$4.7 billion, state will be required to pay for the excess with all state funds. Excess payments will be used to refinance funding for uninsured and underinsured individuals. Under the plan, federal participation will increase by 9% each year.

Under the program, the Vermont Agency of Human Services will contract with the Office of Vermont Health Access to serve as a publicly sponsored managed care organization. The state has the ability to change the benefit package for optional and expansion populations, as long as the total change in spending does not exceed 5%. The plan also makes uninsured individuals with low incomes eligible for premium subsidies based on income and household composition. Subsidies would be used to buy in to employer-sponsored coverage.

Vermont also received approval in June for a long-term care plan, called Choices for Care. This program provides an entitlement to either nursing home care or home and community based services for Medicaid eligible individuals, consistent with their needs and choices. It will operate through a global budget – funds are not allocated in separate silos for nursing home and community-based care, but rather can be spent on whichever service is most appropriate for persons found to be eligible for long-term care.

Vermont is a small state, with only 630,000 residents, an extensive Medicaid infrastructure and residents who trust state government to look out for their needs. The state will continue to cover non-disabled adults without children under existing programs.

West Virginia

West Virginia has developed a draft of a comprehensive Medicaid redesign proposal, but has not yet submitted a waiver to the Centers for Medicare and Medicaid Services. In a draft proposal dated May 4, 2005, the goals of the redesign proposal were to streamline administration; design services to meet the needs of the enrolled population; coordinate care, especially for those with chronic conditions; and provide incentives and opportunities to maintain and improve individuals' health.

West Virginia intends to ask for waivers to eliminate categorical eligibility and allow income levels to become the basis for eligibility. This could be used to implement flexible benefit packages for higher income population groups and create different levels of personal responsibility, incentives, and contributions to healthcare. The state plans to restrict access to some services currently mandated by federal law. Services will be

allocated to reflect best medical practices. The proposed plan would add non-traditional services to certain segments of the population, to be phased in over the first three years of the demonstration. Such services include medical screenings, weight loss assistance, nutrition counseling, addiction counseling, and smoking cessation. Members will enter into personal responsibility agreements, which focus on health maintenance/improvement and disease prevention/maintenance. Eligibility groups would be reduced to children, adults, the disabled, the elderly, and the institutionalized/long-term care, and the services covered would be different based on the eligibility group:

- Children:
 - Cover diagnostic, preventive and treatment of services for both acute needs as well as needed specialized treatment
 - Health screenings should be included in the standards of practice in the medical treatment/management of children in a manner that meets or exceeds the federal requirements but does not require a separate administrative structure to make sure the services are performed
- Adults
 - Basic benefit for healthy adults, reflecting the range of services generally covered in employer-sponsored health plans
 - See Montana 1115 waiver, “Montana Basic Medicaid for Able Bodied Adults”
 - Physician services, diagnostic lab and radiology services limited inpatient hospitalization
- Long-term care/Institutional
 - Goal of reforms is to integrate all long-term care services into a single continuous system of care that is planned, coordinated, and focused on the management of the health needs of each individual. The system would include a single point of entry and would provide care that allows the individual to live in the least restrictive setting possible
 - Eligibility will be based on functional standards and economic circumstances
- Well Elderly
 - Basic benefit for healthy adults, plus services to allow the well elderly to live independently
 - Disease State Management Program services directed to the chronic condition
- Disabled
 - Basic health benefits, lab, radiology, physician, acute-care hospitalization, inpatient mental health
 - Focus on case management/care coordination to assure that specific services are appropriately utilized

West Virginia wants flexibility and freedom from current state plan requirements in the areas of state-wideness, amount, duration and scope of services, comparability, cost-sharing, freedom of choice, and EPSDT. The state is considering the use of Medicaid

Health Investment Accounts to give members incentives for preferred behavior, which could then be used to pay for co-payments, prescription drugs, and other services. West Virginia also plans to increase the use of electronic health records and will seek grants to expand the existing VISTA system (Veteran's Administration electronic health records software).

West Virginia also currently has a Small Business Plan, whose goal is to help make employer-sponsored coverage more affordable. The plan was part of SB 143, which was enacted in 2004. Small businesses must have been without company-sponsored coverage for at least the past 12 consecutive months; have 2-50 employees, the employer must be willing to pay at least 50% of the cost of an individual policy, and the business must have been in operation for at least the past 12 consecutive months. Private insurance companies underwrite all risks and perform administrative duties, while the West Virginia Public Employees Insurance Agency (PEIA) allows use of its lower service payment rates, and physicians and other providers agree to accept PEIA rates.

TIMELINE FOR REFORM

The following is a timeframe to work from as the state moves toward a reformed Medicaid program. The Commission recognizes that some recommendations may take shorter or longer depending on circumstances ostensibly beyond the control of the state.

Top Ten Executables

1. Expand the MC+ coordinated care program to Northwest Missouri.
2. Implement a Chronic Care Improvement Program.
3. Implement and expand the MedStat program to reduce waste, fraud and abuse.
4. Upgrade the Medicaid Management Information System program.
5. Begin a pilot program for e-prescribing to reduce prior authorization concerns.
6. Evaluate and analyze ways to decrease ER over utilization.
7. Require the Division of Medical Services to participate in the Missouri Quality Award process.
8. Implement technological tools that will link the provider to Pharmacy Claim data.
9. Encourage the Missouri Consolidated Health Care Plan to offer optional long-term care insurance.
10. Establish the Joint Committee on Health.

Short-term implementation (Less than 2 years)

Wellness, Prevention and Responsibility

1. A program that emphasizes personal responsibility, health literacy, and creates a structure to guide participants to become better consumers of healthcare.
2. A program that encourages preventive care through health maintenance, evidence based health promotion and education programs.
3. A program that provides basic level of services for each individual, including annual physical and preventive screenings (those identified as evidence based, cost-effective by age, etc.).
4. Develop and create nurse information and triage lines.
5. Establish and expand use of preventive services and evidence-based practice with chronically ill participants. This would include use of tools such as chronic care management, paying for care according to established standards of care and paying for tobacco cessation counseling.
6. Encourage schools to promote healthier lifestyle choices for students in the areas of nutrition and physical activities.

Provider Participation and Satisfaction

7. Explore a system whereby emergency room physicians are allowed to screen patients and refer them to the appropriate level of care.
8. Explore mechanisms to prevent fraudulent providers from doing business in Missouri.
9. Implement provider performance and technological advancements.
10. Through the use of technology improve the prior authorization and claims payment process.

Coordinated Care

11. Expand coordinated care into other geographic areas around the suburban rings.
12. Implement medical loss ratios into any new contract and require the contract to include customer protections and high levels of customer satisfaction.

Technology

13. Increase reimbursements to providers that implement EMRs, CHRs, Personal Health Records and E-Prescribing.
14. Encourage providers to invest in telemonitoring and telemedicine.
15. Offer technical assistance for implementation of EMRs, CHRs, Personal Health Records, telemonitoring and telemedicine.

Mental Health

16. Evaluate the mental health responsibilities and resources across state agencies to identify additional resources and efficiencies that can be gained.
17. Develop provider profiling that gives consumers adequate mental health information.
18. Continue to promote local investment in services and supports by county developmental disabilities mill tax boards.
19. Continued collaboration among departments to assure that evidence based practices are used in behavioral health programs and that care management technologies are used to promote efficiency and consumer choice without inappropriate restricting of availability.
20. Support a public health approach that emphasizes prevention, early intervention and integration of primary care with basic behavioral health services.
21. Ensure that DMH is responsible for establishing appropriate standards of care.
22. Support approaches to strengthen the linkages between federally qualified health centers and community mental health centers.

Long-Term Care

23. Increase education and outreach efforts to encourage the purchase of long-term care insurance, particularly for younger consumers.
24. Examine opportunities to participate in the federal long-term care partnership pilot project.
25. Examine new community-based options and expand the PACE model to other sites in the state and encourage cooperative agreements between all long-term care providers to encourage and promote appropriate options for consumers.
26. Examine the use of division of assets for home and community based services for individuals under the age of 63.
27. Review licensure and oversight requirements for all types of long-term care providers.
28. Explore and implement quality control indicators and oversight for licensed Home and Community Based Care providers.
29. Offer and educate state employees on the importance of obtaining Long-Term Care insurance.

Pharmacy

30. Continue and enhance the collaborative efforts of the Division of Medical Services and the Department of Mental Health through their common partner Comprehensive NeuroScience.
31. Continue to expand and update preferred drug and supplemental rebate opportunities.
32. Enhance current and develop additional clinical and fiscal on-line edits.
33. Improve and expand step therapies as supported by best practice and current medical evidence.
34. Update and expand MAC pricing of generically available products.
35. Expand cost avoidance through required third party billing.
36. Support targeted prior authorization with as much transparency as possible.
37. Continue maximizing other processes already in place that ensure maximum cost containment and appropriate drug usage based on best practices and current medical evidence.

Improving Availability of Quality Care

38. Assist communities in starting or expanding FQHCs through technical assistance for the grant process.
39. Explore a dental care carve-out program from the coordinated care program.
40. Recommend providing leadership by requiring Missouri Consolidated Health Care Plan to offer HSAs as a choice to state employees.
41. Require the Division of Medical Services to participate in the Missouri Quality Award process.

Eligibility

42. Maintain flexibility to allow for the appropriate use of state funds to meet the healthcare needs of Missourians.
43. Establish a new Disabled Employee's Health Assistance Program (DEHAP).

Long-term implementation (more than 2 years)

Wellness, Prevention and Responsibility

1. Create data and automation systems that provide critical information about the population served, financial issues, critical management information and health outcomes to support decision making by factual information.
2. Implement technology that provides central point of entry for all state services.
3. Integrate prevention into the use of technology through electronic medical records to empower individual and community level health decision and integrations/coordination of care by providers.

Provider Participation and Satisfaction

4. Explore mechanisms to prevent provider fraud.
5. Restructure provider reimbursement rates.
6. Explore a tiered level of co-pays to assist with patient compliance and empowerment.

7. Centralize and integrate claims systems as to prevent provider fraud.

Coordinated Care

8. Expand coordinated care to the ABD population through a pilot program.
9. Establish an administrative services organization (ASO) to run the coordinated care for the ABD population through a pilot program in existing coordinated care areas.

Technology

10. All Medicaid providers should have E-Prescribing capabilities in their offices within five years.
11. All Medicaid providers should have Electronic Medical Records within ten years.

Mental Health

12. Seek Medicaid waivers to assure that an appropriate array of services and supports are available for individuals with developmental disabilities and (2) serious mental illnesses or emotional disorders who are eligible through the PTD category.
13. Implement a pilot coordinated care program by DMH for individuals with serious mental illnesses.
14. Support local investment in mental health services and supports, and to develop mechanisms that reduces fragmentation at the local level and appropriately balance state and local control.
15. Promote the use of new technologies, such as telemedicine and electronic medical records.
16. Incentives are developed to promote expansion of employer sponsored benefit plans that include coverage of basic behavioral healthcare.

Long-Term Care

17. Create a mechanism that educates and informs consumers about all of their options for receiving long-term care.
18. Examine the pathway to safety issue to encourage safety and the placement in the least restrictive environment.
19. Establish a single point of entry that includes a statewide-standardized assessment, evaluates the needs of the individuals and provides information about all long-term care options that are available.
20. Utilize technology to better manage information about long-term care consumers and plan for future needs.
21. Revise the Medicaid nursing home reimbursement system to take into account the acuity of the residents in the facility.

Pharmacy

22. Support the inclusion of new technology as it becomes available especially in the areas of electronic prescribing and electronic medical records.

Improving Availability of Quality Care

23. Ensure that all Medicaid participants have availability to a Medical Home where a primary care case manager will be available to assist in their healthcare decisions.
24. Fund and/or facilitate public-private partnerships to promote the availability of healthcare, such as the examples stated above.
25. Look into expanding employer-based coverage by providing affordable coverage to small businesses and the employees.
26. Continue to explore allowing small business and uninsured employees to buy into the state-employee health plan, Missouri Consolidated Health Care Plan.
27. Institute a combination of individual healthcare tax credits and tax credits for small employers.
28. Offering a high deductible individual health insurance plan at an affordable rate but with a certain level of benefits.

Eligibility

29. Establish a tiered benefit package based on the healthcare needs and category of the participant.

Conclusion

A transformed Medicaid program is necessary if we are to continue to provide for our most vulnerable citizens. This reform cannot be done in a vacuum and must take into consideration the entire healthcare industry, public and private. Reform will take place at all levels of government. Federal waivers must be issued, administrative changes must be instituted and statutory changes will be passed. There must also be efforts at the local and community level. Local officials are more inclined to know the needs of their citizens and what works for their communities. This report and its recommendations provide a structure for a reformed Medicaid program that will provide quality care while spending taxpayers' money in an efficient cost-effective manner.

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- ⁴ A Profile of Medicaid: Chartbook 2000, U. S. Department of Health and Human Services, September, 2000. *Also see: Medicaid: A Brief Summary*, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, <http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>, last modified December 3, 2004.
- ⁵ *Ibid*
- ⁶ MC+/Medicaid Enrollees and Expenditures, SFY-92 to SFY-05 YTD, Missouri Department of Social Services, presented to the Medicaid Reform Commission on June 29, 2005.
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- ⁹ Medicaid Enrollees and Expenditures, Missouri Department of Social Services. Presented to the Medicaid Reform Commission on June 29, 2005.
- ¹⁰ *Ibid*
- ¹¹ *Ibid*
- ¹² Mo. Rev. Stat. §192.068, 2000.
- ¹³ Managed Care Performance Monitoring, Missouri Department of Health and Senior Services, <http://www.dhss.mo.gov/ManagedCare/>, viewed on September 29, 2005.
- ¹⁴ Elderly and disabled individuals currently do not receive care through a managed care plan.
- ¹⁵ 2005 Consumer's Guide MC+ Managed Care in Missouri, Missouri Department of Health and Senior Services (Web site)
- ¹⁶ Medicaid: Missouri's Public Health Care Program, Missouri Academy of Family Physicians Medicaid Task Force, Family Physician Feedback, September 2005.
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- ¹⁸ *Ibid* at 13.
- ¹⁹ Testimony of David O. Barbe, MD, presentation of the Missouri State Medical Association to the Medicaid Reform Commission by Dr. David O. Barbe, June 29, 2005.
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- ²⁴ *Ibid*
- ²⁵ Centers for Disease Control and Prevention
- ²⁶ Medicaid Reimbursement Survey, 2004/2005, American Academy of Pediatrics, http://www.aap.org/research/medreimPDF05/Medicaid_Reimbursement_2004-05_Interim_Report.pdf ; and Medicaid Reimbursement for Commonly Used Pediatric Services, 2004/05, Interim Report, American Academy of Pediatrics, <http://www.aap.org/research/medreimpdf0405/mo.pdf>
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- ³⁰ New Freedom Commission Interim Report, p.4-5.
- ³¹ Conclusions, 2000 Census Data, Missouri Department of Health and Senior Services
- ³² *Ibid*
- ³³ Missouri Department of Social Services, FY 2004
- ³⁴ Missouri Department of Social Services, FY 2004

³⁵ 42 U.S.C. §1396r-5. *See also* 13 CSR 40-2.200.

³⁶ *Ibid*

³⁷ Increase in Allotments and the Spousal Share, IM-145, Missouri Department of Social Services, Family Support Division, December 1, 2005.

http://www.dss.mo.gov/fsd/iman/memos/memos_05/im145_05.html

³⁸ Arkansas,, Kentucky, Nebraska, Oklahoma, and Tennessee use the income first method. Illinois, Iowa and Kansas use the asset first method. Missouri enacted legislation in 2005 (SB 539) changing the methodology from asset first to income first.

³⁹ 1998 State Data Book, Centers for Medicare and Medicaid Services,
<http://www.cms.hhs.gov/medicaid/services/98sdbltc.pdf>

⁴⁰ See note 19

⁴¹ Written testimony by the Missouri Primary Care Association, presented October 21, 2005.

⁴² Written testimony by the Missouri Dental Association, presented October 13, 2005.

⁴³ *State Options for Expanding Health Care Access-Balancing Health Needs with Resources- Analysis of Provocative Ideas in Health Care*, March 2004. Barbara Yondorf, Laura Tobler and Leah Oliver, National Conference of State Legislatures

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